UK Focal Point On Drugs

United Kingdom Drug Situation 2017

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United Kingdom Drug Situation: Focal Point Annual Report 2017

Editors

Catherine Crawford, Tom Clare, Casey Sharpe and Craig Wright

United Kingdom Focal Point at Public Health England
7th floor, Wellington House, 133-155 Waterloo Road, London,
SE1 8UG, United Kingdom

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The United Kingdom Focal Point on Drugs

The United Kingdom Focal Point on Drugs (UK Focal Point) is based at Public Health England. It is the national partner of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) and provides comprehensive information to the centre on the drug situation in England, Scotland, Wales and Northern Ireland. The Focal Point works closely with the Home Office, other government departments and the devolved administrations in meeting the UK's reporting obligations to the EMCDDA and to other international bodies. The Focal Point also provides the secretariat for several UK expert networks, and manages the early warning system for new psychoactive substances with Liverpool John Moores University. Previous annual reports can be found at www.gov.uk/government/publications/united-kingdom-drug-situation-focal-point-annual-report

If you have any queries relating to this report, please contact ukfocalpoint@phe.gov.uk

The EMCDDA's website is www.emcdda.europa.eu

National Contributors

Home Office	Dan Broadfield Ben Bryant Jenny McCurry James McLellan
Scottish Government	William Doyle
Information Services Division, National Health Service, Scotland	Lee Barnsdale
Welsh Government	Christopher Gittins Rhian Hills
Public Health Wales	Josie Smith
Department of Health, Northern Ireland	Deirdre Corrigan Gary Maxwell

Experts on the EMCDDA Key Epidemiological Indicators

Population prevalence	Craig Wright	Public Health England
Problem prevalence	Gordon Hay	Liverpool John Moores University
Treatment demand	Craig Wright	Public Health England
Drug-related deaths	Martin White	Public Health England
Drug-related infectious diseases	Vivian Hope	Public Health England and Liverpool John Moores University

Main Contributors for Individual Chapters

Overview of illicit drug use in the United Kingdom	Casey Sharpe Catherine Crawford Craig Wright	UK Focal Point UK Focal Point UK Focal Point
Drug policy	Tom Clare Casey Sharpe Craig Wright	UK Focal Point UK Focal Point UK Focal Point
Prevention	Tom Clare	UK Focal Point
Treatment	Catherine Crawford	UK Focal Point
Drug users in prison and the broader criminal justice system	Catherine Crawford	UK Focal Point
Drug-related deaths	Tom Clare Martin White	UK Focal Point Public Health England
Drug-related infectious diseases and other harms	Tom Clare Vivian Hope	UK Focal Point Public Health England and Liverpool John Moores University
Drug laws and offences	Catherine Crawford Casey Sharpe	UK Focal Point UK Focal Point
Drug markets	Tom Clare Catherine Crawford Richard Prosser	UK Focal Point UK Focal Point National Crime Agency

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- staff in the Alcohol, Drugs and Tobacco division of ***Public Health England***

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£	Pound sterling (UK)
µg	Microgram
ACM	All-Cause Mortality
ACMD	Advisory Council on the Misuse of Drugs
AD:EPT	Alcohol and Drugs: Empowering People through Therapy
ADEPIS	Alcohol and Drug Education and Prevention Information Service
ADP	Alcohol and Drug Partnership
Anti-HBc	Antibodies to Hepatitis B Core Antigen
Anti-HCV	Antibodies to Hepatitis C Virus
APB	Area Planning Board
APoSM	Advisory Panel on Substance Misuse
APT	Addiction Prevalence Test
AYPH	Association for Young People's Health
BBV	Blood-Borne Virus
CAYT	Centre for the Analysis of Youth Transitions
CCEA	Council for Curriculum, Examinations and Assessment
CHI	Community Health Index
CI	Confidence Interval
CJEU	Court of Justice of the European Union
CJS	Criminal Justice System
CQC	Care Quality Commission
CRC	Community Rehabilitation Company
CSEW	Crime Survey for England and Wales
CSP	Community Safety Partnership
DAISy	Drug and Alcohol Information System
DfE	Department for Education
DH	Department of Health
DHSC	Department of Health and Social Care
DIP	Drug Interventions Programme
DMD	Drug Misuse Definition
DoH	Department of Health (Northern Ireland)
DRD	Drug-Related Death
DRP	Drug-Related Poisoning
DRR	Drug Rehabilitation Requirement
DTTO	Drug Treatment and Testing Order
DWP	Department for Work and Pensions
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
ERANID	European Research Area Network on Illicit Drugs

EU	European Union
Euro-DEN	European Drug Emergencies Network
FDAC	Family Drug and Alcohol Court
g	Gram
GAS	Group A Streptococcal
GBL	Gamma-butyrolactone
GBP	Great British Pounds (sterling)
GHB	Gamma-hydroxybutyrate
GMR	General Mortality Register
GP	General Practitioner
GPS	General Population Surveys
HBsAg	Hepatitis B Surface Antigen
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HEAT	Health Improvement, Efficiency, Access and Treatment
HIV	Human Immunodeficiency Virus
HJIP	Health and Justice Indicators of Performance
HMP	Her Majesty's Prison
HMPPS	Her Majesty's Prison and Probation Service
HMYOI	Her Majesty's Young Offender Institution
HRD	Harm Reduction Database
HSCP	Health and Social Care Partnership
ICD-10	International Statistical Classification of Diseases and Related Health Problems - Tenth Edition
IDU	Injecting Drug Users
iGAS	Invasive Group A Streptococcal
IJB	Integration Joint Board
IPED	Image and Performance Enhancing Drug
IPS	Individual Placement and Support
kg	Kilogram
L&D	Liaison and Diversion
LA	Local Authority
LDP	Local Delivery Plan
LDSS	Low Dead Space Syringes
LSD	Lysergic Acid Diethylamide
MDMA	3,4-Methylenedioxymethamphetamine
MDT	Mandatory Drug Testing
mg	Milligram
MHRA	Medicines and Healthcare products Regulatory Agency
ml	Millilitre
MoJ	Ministry of Justice

MRSA	Meticillin-resistant Staphylococcus aureus
MSM	Men who have Sex with Men
MSSA	Meticillin-sensitive Staphylococcus aureus
MUP	Minimum Unit Price/Pricing
NCA	National Crime Agency
NDRDD	National Drug-Related Deaths Database
NDTMS	National Drug Treatment Monitoring System
NEPTUNE	Novel Psychoactive Treatment UK Network
NESI	Needle Exchange Surveillance Initiative
NGO	Non-Governmental Organisations
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
NIPS	Northern Ireland Prison Service
NNAG	National Naloxone Advisory Group
No.	Number
NOMS	National Offender Management Service
NPIS	National Poisons Information Service
NPS	New Psychoactive Substances
NPSAD	National Programme on Substance Misuse Deaths
NQA	National Quality Award
NRS	National Records of Scotland
NRT	Nicotine Replacement Therapy
NSD	New Strategic Direction
NSP	Needle and Syringe Programmes
OCG	Organised Crime Group
ONS	Office for National Statistics
OST	Opioid Substitution Treatment
PADS	Partnership for Action of Drugs in Scotland
PbR	Payment by Results
PDU	Problem Drug Use
PHA	Public Health Agency for Northern Ireland
PHE	Public Health England
PND	Penalty Notice for Disorder
PPO	Prisons and Probation Ombudsman
PSA	Psychoactive Substances Act
PSHE	Personal, Social and Health Education
PWID	People Who Inject Drugs
py	Person-Years
RIDR	Report Illicit Drug Reactions
RPW	Recorded Police Warning
SALSUS	Scottish Schools Adolescent Lifestyle and Substance Use Survey

SAPM	Sheffield Alcohol Policy Model
SARG	Sheffield Alcohol Research Group
SCJS	Scottish Crime and Justice Survey
SCRA	Synthetic Cannabinoid Receptor Agonist
SDD	Smoking Drinking and Drug Use Among Young People in England Survey
SEHSCT	South Eastern Health and Social Care Trust
SPS	Scottish Prison Service
SWA	Scotch Whisky Association
TAS	Throughcare Addiction Service
TB	Tuberculosis
TCDO	Temporary Class Drug Order
TDI	Treatment Demand Indicator
THC	Tetrahydrocannabinol
THN	Take-Home Naloxone
TOP	Treatment Outcomes Profile
TPD	Tobacco Products Directive
UAM	Unlinked Anonymous Monitoring
UK	United Kingdom
USA	United States of America
VCT	Voluntary Confidential Test/Testing
WEDINOS	Welsh Emerging Drug and Identification of Novel Substances
WNHSS	Welsh Network of Healthy Schools Schemes
YOI	Young Offender Institution
YPBAS	Young Persons' Behaviour and Attitudes Survey

Technical Notes

Accompanying Tables

The accompanying tables referenced in the text are published alongside the report on the Focal Point webpage: https://www.gov.uk/government/publications/united-kingdom-drug-situation-focal-point-annual-report.

Cut-off for updates

The 31st December 2017 was used as the cut-off date for developments or publications to be included in this report. Where the terms 'latest; or 'most recent' are used in relation to statistics, they should be interpreted as meaning the most recent data available as at the end of the calendar year. New statistics, reports, or other relevant developments between the end of the calendar year and the publication of the report have not been factored in.

Executive summary

- Overall drug prevalence in the general population is lower now than ten years ago, with cannabis being the main driver of that reduction; however, there has been little change in recent years (section 1.2.1).
- The order of drugs most commonly reported by respondents to general population surveys has not changed much over this time, with cannabis most prevalent (last year prevalence of 6.6%) followed by powder cocaine (2.3%) and ecstasy/MDMA (1.3%), according to the most recent *Crime Survey for England and Wales* (section 1.3.1 and section 1.4.1).
- Lifetime prevalence of drug use among schoolchildren has previously showed a steady long-term decline; however, data from the most surveys of schoolchildren in both England and Scotland reported increases in drug use. Future surveys will need to be monitored to determine if this is a genuine changing trend in this population (section 1.2.2).
- The most recent available estimates have suggested that there was a ten per cent increase in crack cocaine use in England between 2011/12 and 2014/15. Other indicators support this general picture, with increases seen in the number of those presenting to treatment for crack use in 2016 and in the proportion of injecting drug users using this substance surveyed in the Unlinked Anonymous Monitoring (UAM) survey of people who inject drugs (PWID) (section 1.4.3).
- The UK government published the *2017 Drug Strategy* in July 2017, outlining the overall strategic approach to responding to the drug situation. This strategy, in line with the previous version, aims to reduce demand, restrict supply, and build recovery, with a new aim of global action, and was accompanied by an evaluation of the 2010 drug strategy (section 2.6.1).
- In April 2017 the Department for Work and Pensions published *Improving lives: Helping workless families*, a policy paper which proposed a trial of individual placement and support (IPS) approaches to aid drug users enter or continue to work. The Department for Work and Pensions and Department of Health and Social Care Work and Health Unit have funded a randomised controlled trial of IPS in seven areas, which Public Health England is currently in the process of conducting (section 2.6.3 and section 4.9.6).
- A new NICE guideline, *Drug misuse prevention: targeted interventions (NG64)*, was published in February 2017, replacing the previous guideline PH4 (section 3.7.1).
- The *Children and Social Work Act 2017* came into force in April 2017. In addition to aiming to improve local joint working, the act provides the Education Secretary with powers to make personal, social and health education (PSHE) mandatory in all schools (section 3.7.2).
- There were 119,973 treatment presentations in the UK in 2016. In England and Wales, there were 244,971 individuals recorded as being in drug treatment during 2016. Of all those in treatment in England and Wales, 138,422 were receiving prescribing treatment for opioid use (section 4.3.1).

- Two-fifths (42%) of treatment presentations in the UK were for primary heroin use, with 25% of all service users presenting for treatment of cannabis use. Among those who had never previously been in treatment, 45% of clients presented for primary cannabis use, whereas 16% presented for primary heroin use, representing a five per cent decrease in the proportion of first-time primary heroin clients from 2015 (section 4.3.2).
- As with the previous year, the primary drugs cited by those presenting to treatment services varied notably between the four countries of the UK. While almost half of treatment entrants cited heroin as their primary substance in England, Scotland and Wales, seven per cent of clients in Northern Ireland had this as their primary substance (section 4.3.2).
- Benzodiazepines were cited by a much larger proportion of treatment entrants in Scotland and Northern Ireland than in the rest of the UK, while primary crack cocaine use was more common in England, and amphetamine/methamphetamine use was more common in Wales (section 4.3.2).
- In July 2017, the then Department of Health published an update of the *Drug misuse and dependence: UK guidelines on clinical management*, based on the results of a review of the evidence on drug treatment since 2007 (section 4.7.1).
- Treatment data showed that 29,886 of the clients that presented to treatment in the UK in 2016 did so within a prison setting, made up of 27,575 individuals in England, 1,778 in Scotland, and 533 in Northern Ireland (section 5.5.1).
- Use of synthetic cannabinoid receptor agonists (SCRAs) in prisons remains a problem. Testing data published this year suggested that SCRAs are the most commonly used substance in prisons, with 16% of prisoners testing positive for these substances on release from prison, compared to nine per cent on arrival (section 5.3.2).
- The Prisons and Probation Ombudsman reported that between June 2013 and September 2016 there were 79 deaths in prisons in England and Wales where the deceased was known or strongly suspected to have taken new psychoactive substances (NPS) before death, or where NPS use was a key issue during their time in prison. Of the 79 deaths, 56 were self-inflicted (section 5.4.2).
- National take-home naloxone programmes continue to supply naloxone to those exiting prison in Scotland and Wales: there were 720 kits issued by NHS staff in prisons in Scotland, and 655 in Wales, in 2016/17 (section 5.5.3).
- Using the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) definition, the total number of drug-related deaths (DRDs) that occurred in the UK during 2015 was 3,070, a 13% increase from 2014 and the highest number reported to date (section 6.3).
- Due to delays between occurrence and registration of DRDs in England and Wales, UK-wide DRD figures are not yet available covering deaths occurring beyond 2015. However, published statistics for DRDs occurring in Scotland during 2016 showed a 23% increase on 2015, and deaths registered in England & Wales in 2016 showed a four per cent increase. It is therefore likely that the figure for UK DRDs occurring in 2016 will again show an increase on the previous year (section 6.3).
- Across the UK there were 2,656 deaths reported which featured an opioid (87% of UK cases) (section 6.5.1). As in previous years, the substance with the largest number of associated deaths was heroin. In contrast to the UK as a whole, tramadol was the most commonly mentioned opioid in Northern Ireland (section 6.5.2).

- The proportion of deaths involving cocaine has continued to rise. Many of these deaths are believed to be heroin users who also use crack cocaine (section 6.5.2).
- There was a substantial increase in the number of deaths registered in Scotland in 2016 that involved a benzodiazepine, rising from 191 deaths in 2015 to 426 in 2016. Etizolam, classified as an NPS, was implicated in, or contributed to, the largest proportion of these cases (n=225, up from 43 cases in 2015) (section 6.5.2).
- There was a spate of deaths related to fentanyls (particularly carfentanyl) in the first half of 2017. This particular incident abated; however, concern remains that there is demand for these drugs if supply were to be re-established (section 6.9.3).
- Over the last decade the average age at death has increased from 37.6 years in 2004 to 42.1 in 2015, with males being younger than females (41.3 years and 44.5 years respectively) (section 6.6.4).
- Around 90% of the hepatitis C infections diagnosed in the UK are acquired through injecting drug use. The prevalence of hepatitis C among PWID has remained fairly stable over the last ten years, and was 53% in the UAM survey of PWID in 2016 (section 7.2.1).
- Hepatitis B and HIV prevalence rates have remained stable in 2016 at 14% and 0.85%, respectively, in the UAM survey of PWID (section 7.2.2. and section 7.2.3).
- The level of direct sharing of needles and syringes reported by participants in the UAM survey of PWID has declined over the last decade from 28% in 2005 to 17% in 2016 (section 7.5.1). However, there are concerns around an increasing trend of injecting stimulants (section 7.5.2).
- Following the introduction of the *Psychoactive Substances Act 2016*, over 300 retailers across the UK have either closed down or stopped selling psychoactive substances, police have arrested suppliers, and action by the National Crime Agency has resulted in the removal of psychoactive substances being sold by UK-based websites (section 8.2.3).
- Substances classified under the *Misuse of Drugs Act 1971* during 2017 include 'designer benzodiazepines' (including etizolam), U-47,700 (a synthetic opioid), methylphenidate-related substances (including ethylphenidate) and methiopropamine (section 8.4.1).
- Most proven drug law offences in the UK relate to cannabis: in 2015 there were 42,065 recorded possession offences, and 13,717 supply offences. Both possession and supply offences have seen decreases since 2011 (section 8.3.2).
- There has been a downward trend in the overall number of drug seizures made in recent years, mainly due to a decrease in cannabis seizures. Powder cocaine, ecstasy and heroin seizure numbers have all remained stable, while the number of crack seizures increased in 2015/16 (section 9.4.1).
- Heroin purity at user-level has continued to rise since the nadir seen in the early 2010s, and in 2015 was 43%, more than double the purity seen in 2011 and 2012. Similarly, powder cocaine purity, which was at its lowest in 2010, has risen since that time, and in 2016 user-level purity was 54% (section 9.3.5). Crack cocaine purity was the highest recorded in 2016 at 71%.
- Street-level price data from law enforcement agencies suggests that most recorded drug prices have remained stable in recent years (section 9.3.3).

1 Overview of illicit drug use in the United Kingdom

1.1 Introduction

Overall prevalence of drug use reported in adult general population surveys (GPS) in the UK is lower now than it was ten years ago, but has remained stable in recent years (last year use of any drug currently stands at 8.5% in England and Wales) (Home Office, 2017a). This principally reflects a decline in cannabis use, which, due to its relatively high prevalence, is the main driver of the overall trend. Lifetime prevalence of drug use among schoolchildren previously showed a steadier long-term decline. However, data from the most recent surveys of schoolchildren in both England and Scotland reported increases in drug use, with 37% of 15-year-olds in England in 2016 reporting having ever used drugs, similar to the prevalence seen in 2008 (38%) (NHS Digital, 2017b)(NHS Digital, 2017; Scottish Government, 2016b).

GPS indicate that cannabis is the most commonly used illicit drug in the UK, and it has been in each year that relevant surveys have been conducted. Seizures data suggests that while resin was by far the most common form of cannabis at the turn of the century, the availability of herbal cannabis has increased since and now dominates the UK market. Treatment demand for cannabis has risen for as far back as there is reliable data, despite prevalence having fallen. Cocaine (in powder form) is the next most commonly used drug, followed by ecstasy/MDMA.

Although its use in the general population is relatively uncommon (Home Office, 2017a), heroin is associated with causing substantial health and social harm to users as well as the most harm to society (for example in the form of drug-related crime). As such, heroin is of particular importance to policy-makers in the UK. Around two-thirds of people in drug treatment in England cite heroin as a problematic substance (see section 4.3.2). More than half (55%) of all drug-related deaths registered in Scotland in 2016 involved heroin, with 47% of drug misuse deaths registered in England and Wales in the same year involving this substance, making heroin the most commonly cited drug at death in these countries (see section 6.5.2). Crack cocaine is commonly cited as an adjunctive drug by heroin clients in treatment, but its use among the general population is rare in comparison to that of powder cocaine. However, a number of indicators suggest that use of crack has been increasing, and has been associated with risky injection practices (see section 7.5.2). Poly-use of benzodiazepines and heroin is also common in the UK, particularly in Scotland.

Although the prevalence of new psychoactive substances (NPS) use reported in GPS is low in comparison to the main 'traditional' drugs (Home Office, 2017a), concerns have emerged in recent years regarding use of synthetic cannabinoid receptor agonists (SCRAs) among prisoners and other vulnerable populations (see chapter 5).

1.2 Overall prevalence of drug use

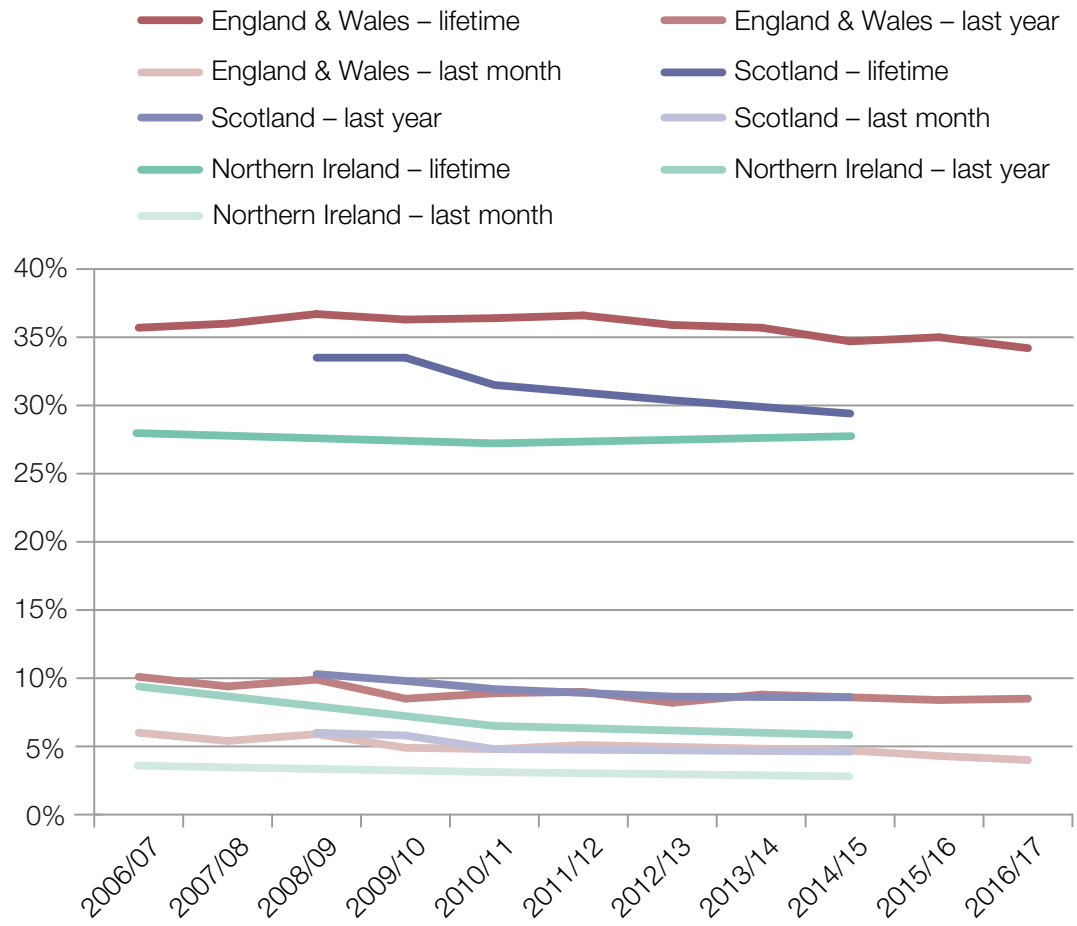
1.2.1 Prevalence of drug use among the general adult population

A large portion of adults living in the UK have used illicit drugs. In the most recent *Crime Survey for England and Wales* (CSEW), 34.2% of adults aged 15 to 59 reported they had used an illicit substance at some point in their life (Home Office, 2017a). This is only a slight decrease from ten years ago (2006/07), when the lifetime prevalence rate was 35.7% (see Figure 1.1). When

participants were asked about their drug use for the previous year, 8.5% reported use, which was lower than 2006/07 reports (10.1%) but higher than the nadir in 2012/13 (8.2%). Prevalence of last month use has dropped from 6.0% to 4.0% over the last decade.

According to the most recent *Scottish Crime and Justice Survey* (SCJS), 29.5% of adults aged 16-59 in Scotland[1] had tried drugs at least once in their lifetime, 8.5% reported use in the last year, and 4.6% reported last month use (Scottish Government, 2016c). Since 2008/09, reported rates of lifetime, last year, and last month use have all decreased (33.5%, 10.3%, and 6.0%, respectively) (see Figure 1.1) (Scottish Government, 2010a).

Figure 1.1: Percentage of adult respondents to prevalence surveys across the United Kingdom reporting lifetime, last year or last month use of illicit drugs, by country, 2006/07 to 2016/17†*



*Scottish data is for 16-59 year-olds rather than for all adults, as published in the SCJS headline figures. England and Wales data is for 16-59 year-olds; Northern Ireland data is for 15-64 year-olds

†Surveys were conducted in different years for each country. Data collection years were as follows: England and Wales from 2006/07 to 2016/17 ('last month' data was not collected for 2012/13 and 2013/14); Scotland from 2008/09 to 2010/11, 2012/13, and 2014/15; and Northern Ireland from 2006/07, 2010/11, and 2014/15

Source: (Home Office, 2017a; National Advisory Committee on Drugs and Alcohol & Department of Health Northern Ireland, 2017; Scottish Government, 2016c)

Northern Ireland has the lowest overall reported drug use in all categories.[2] The 2014/15 *Drug use in Ireland and Northern Ireland – Drug Prevalence Survey* found that less than three per cent (2.9%) of adults aged 15-64 reported use within the last month, while 5.9% reported use

1 Scottish adult data is for 16-59 year-olds rather than for all adults, as published in the SCJS headline figures

2 It should be noted that there are differences in data collection methods between the three GPS carried out in the UK that make specific values not directly comparable

in the last year, and 27.7% reported using illicit drugs at least once in their lifetime (National Advisory Committee on Drugs and Alcohol & Department of Health Northern Ireland, 2016). Lifetime prevalence has changed little over the last ten years in Northern Ireland (28.0% in 2006/07), but last year use and last month use have seen notable decreases (9.4% and 3.6%, respectively) (see Figure 1.1).

1.2.2 Prevalence of drug use among schoolchildren

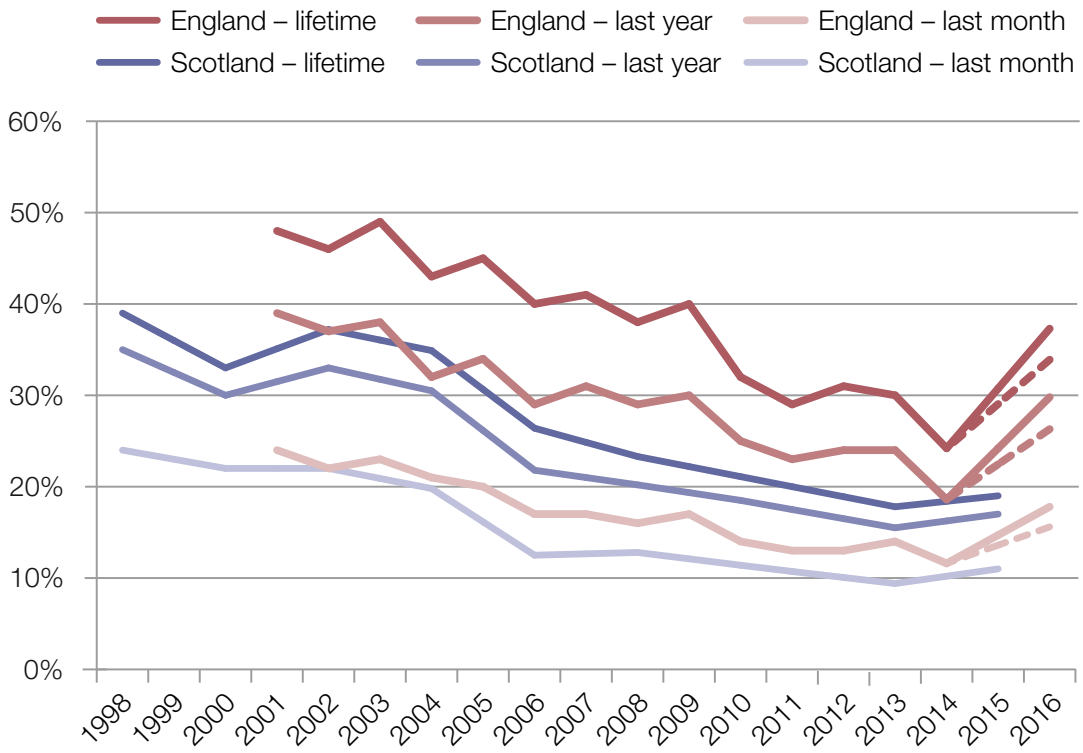
The three surveys which look at substance use in people of school age in the UK are the *Smoking, drinking and drug use among young people in England survey* (SDD), the *Scottish Schools Adolescent Lifestyle and Substance Use Survey* (SALSUS), and the *Young Persons' Behaviour and Attitudes Survey* (YPBAS) in Northern Ireland (Health and Social Care Information Centre, 2015; Northern Ireland Statistics and Research Agency, 2017b; Scottish Government, 2016d).

Data from the SDD has shown a long-term decrease in prevalence of drug use among 15-year-olds in England (see Figure 1.2) (NHS Digital, 2017b). However, in 2016 (the most recent survey), 37.3% of pupils aged 15 years old had ever taken drugs, 29.8% had used drugs in the last year, and 17.8% had used drugs in the last month, which were all substantial increases from the previous survey. This increase may be partially explained by changes made to the most recent survey which for the first time included questions related to NPS and nitrous oxide use, although when these questions were removed there was still a prominent increase compared to last year's responses. The proportion of 15-year-olds reporting drug use in England has been consistently higher than in Scotland in years when both the SDD and SALSUS have been conducted.

The SALSUS collects responses from 13- and 15-year-old pupils on their reported substance use behaviours but, to increase comparability between youth surveys, only responses from 15-year-old respondents will be reported here. Following long-term decreases in prevalence of drug use, there were small increases in use reported in the most recent SALSUS, carried out in 2015 (see Figure 1.2). Nineteen per cent of 15-year-olds stated they had ever used drugs, with 17% having used drugs in the past year (Scottish Government, 2016d). Eleven per cent of 15-year-olds reported having used drugs in the month prior to the survey.

The most recent YPBAS, which collected responses from Northern Irish schoolchildren aged 11 to 16, reported substantially lower rates of use than the SALSUS and SDD, with lifetime prevalence for all ages at 4.5% for 2016 (Northern Ireland Statistics and Research Agency, 2017b). In comparison, 24% of all 11- to 15-year-olds in the SDD reported lifetime use of drugs in 2016 (NHS Digital, 2017b).

Figure 1.2: Percentage of 15-year-olds reporting lifetime, last year and last month use of drugs in the Smoking, Drinking and Drug Use among Young People in England survey, 2001 to 2016, and the Scottish Schools Adolescent Lifestyle and Substance Use Survey, 1998 to 2015*



*Dotted lines indicate trends with NPS/nitrous oxide data excluded

Source: (NHS Digital, 2017b; Scottish Government, 2016d)

1.2.3 Prevalence of problem drug use among adults

Due to the association between particular drugs (especially opioids) and both individual and societal harms, estimating the size of the problem drug using population is a key element of the evidence base used to formulate policy and inform service provision. It additionally provides a context in which to understand the population impact of interventions to reduce drug-related harm. Direct enumeration of those engaged in a largely covert activity such as the use of heroin is not possible, and household surveys such as the CSEW underestimate numbers of those individuals whose drug use is the most problematic (Home Office, 2017a). Instead, indirect techniques can be applied to provide estimates of problem drug use (PDU) prevalence.

PDU is defined slightly differently by each country of the UK. Estimates are derived using two indirect measurement techniques: the capture-recapture method; and the multiple-indicator method. In England, estimates are produced for opioid and/or crack cocaine users (together and separately); the latest estimates covered 2014/15 (Hay, Rael dos Santos, & Swithenbank, 2017). It should be noted that the case definition focuses on 'use' of opioids and/or crack cocaine rather than the 'misuse'/addiction to these drugs; the estimates therefore include people using prescribed opioids such as methadone and buprenorphine. In Scotland, PDU refers to the problematic use of opioids and/or the illicit use of benzodiazepines and drug injecting; the latest estimates are for 2012/13 (Information Services Division, 2014a). In Wales, the most recent estimates look at injecting drug use or long duration/regular use of opioids, cocaine and/or amphetamines, and covered 2015/16. The last estimates in Northern Ireland covered 2004 and estimated high risk opioid and/or problem cocaine powder use. The most recent estimates of the numbers of problem drug users in Great Britain are shown in Table 1.1.

Table 1.1: Estimated number of problem drug users in Great Britain, and rate per 1,000 population aged 15 to 64, by country

Country	Year	Number of problem drug users			Rate per 1,000 population		
		Estimate	95% Confidence Interval		Estimate	95% Confidence Interval	
England	2014/15	300,783	297,986	311,128	8.57	8.49	8.86
Scotland	2012/13	61,500	59,900	63,300	17.44	16.98	17.95
Wales	2015/16	49,370	42,230	58,540	25.3	21.6	29.9

Source: (Hay et al., 2017; Information Services Division, 2014a), Accompanying table 2.1

1.3 Cannabis

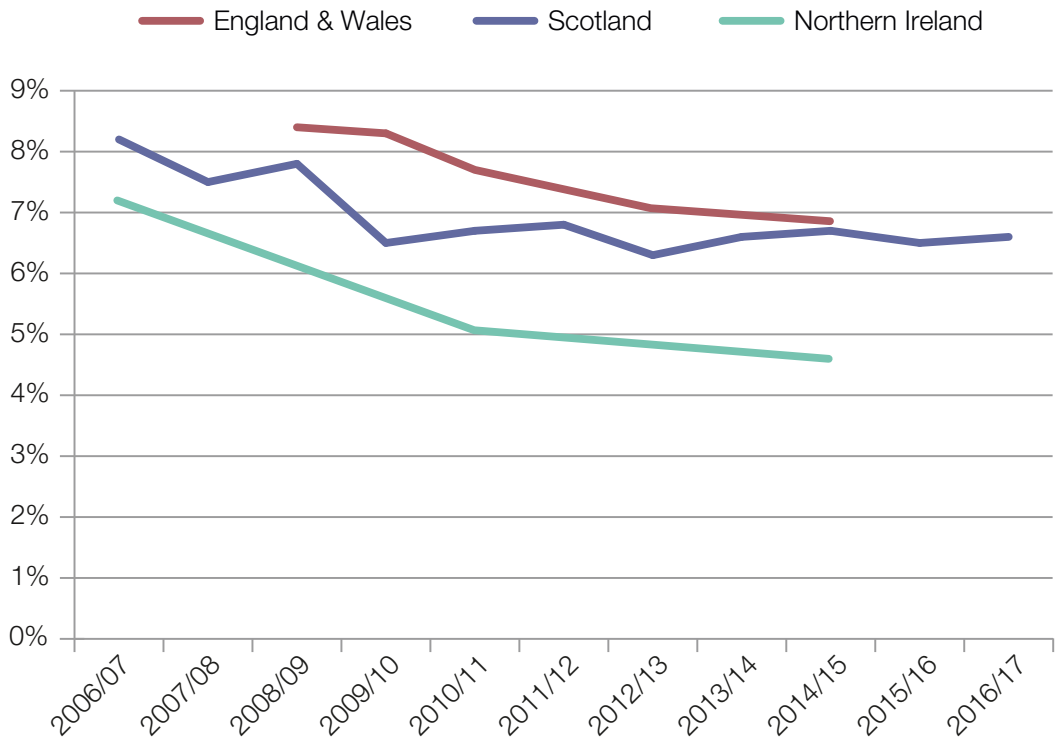
1.3.1 Prevalence of cannabis use

Cannabis is the most commonly reported drug used in GPS carried out in each country of the UK, and has been in each year that any of these surveys has been conducted. The most recent CSEW reported that the prevalence of last year cannabis use was 6.6% in 2016/17, in comparison to 2.3% of respondents using powder cocaine, the second most commonly reported illicit drug (Home Office, 2017a). Use of cannabis in the general population had been on a long-term downward trend since 2003/04, but the trend since 2009/10 has been relatively flat (see Figure 1.3). In the early 2000s, prevalence of last year cannabis use reported by the CSEW was among the highest reported by European countries; however, this is now at a level that is fairly typical to that seen elsewhere (European Monitoring Centre for Drugs and Drug Addiction, 2017).

Use of cannabis is most common among younger survey respondents and the long-term downward trend is also more apparent among this group, with last year prevalence for 16-24 year-olds decreasing from a high of 28.2% in 1998 to 16.4% in 2016/17 (Home Office, 2017a). As with prevalence of use among all adults, this declining trend has levelled out since 2009/10.

Similar prevalence of last year cannabis use has been reported in the other countries of the UK (see Figure 1.3). The SCJS covering 2014/15 showed last year use among the 16-59 age group as 6.9% (Scottish Government, 2016c). As with most drugs, use of cannabis is lower in Northern Ireland than the other countries of the UK, with the most recent *Drug use in Ireland and Northern Ireland – Drug Prevalence Survey* reporting last year cannabis use at 4.6% in 2014/15 (National Advisory Committee on Drugs and Alcohol & Department of Health Northern Ireland, 2016).

Figure 1.3: Percentage of adult respondents to prevalence surveys across the United Kingdom reporting last year use of cannabis, by country, 2006/07 to 2016/17*



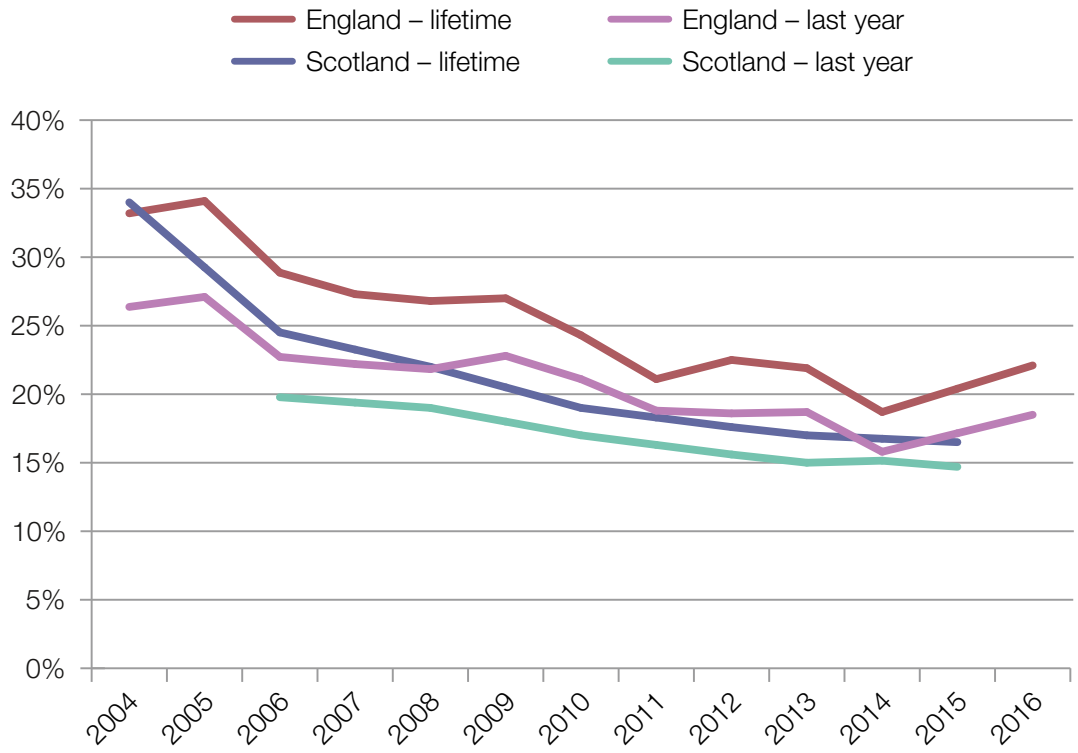
*Scottish data is for 16-59 year-olds rather than for all adults, as published in the SCJS headline figures. England and Wales data is for 16-59 year-olds; Northern Ireland data is for 15-64 year-olds

Source: (Home Office, 2017a; National Advisory Committee on Drugs and Alcohol & Department of Health Northern Ireland, 2017; Scottish Government, 2016c)

Rates of use of cannabis in the last month are fairly similar across the UK: 3.2% in England and Wales in 2016/17; 3.8% (for 16-59 year-olds) in Scotland in 2014/15; and 2.2% in Northern Ireland in 2014/15. The proportion of last year cannabis users in England and Wales that reported having done so more than once a month has fallen in recent years, from 45% in 2009/10 to 37% in the last CSEW (Home Office, 2017a). Despite the decrease, this remains a very high proportion of last year users compared to other drugs. Of the individuals reporting last month use of cannabis, the proportion that reported daily or almost daily use increased over the past two years, from 14% in 2015/16 to 27% in 2016/17.

The decrease (and possible levelling out) in cannabis use seen in the general population has also been present among respondents to school surveys (see section 1.2.2), although as with prevalence of any drug use, the most recent surveys have shown an increase in the proportion of children reporting cannabis use. Cannabis continues to be the most popular drug reported in these surveys, with 18.5% of SDD 2016 respondents (aged 15) and 14.7% of SALSUS 2015 respondents (aged 15) reporting having used cannabis in the previous year (see Figure 1.4) (NHS Digital, 2017b; Scottish Government, 2016d). Prevalence of use among school-age children in Northern Ireland was lower than in other countries (Northern Ireland Statistics and Research Agency, 2017b); 3.3% of 11-16 year-old YPBAS 2016 respondents reported having ever used cannabis compared to 9.4% of 11-15 year-old SDD respondents in 2016. Data from the SDD and SALSUS shows that the likelihood of having ever used cannabis increases with age, with 0.6% of 11-year-olds having done so compared with 22.1% of 15-year-olds in the 2016 SDD, and 3.3% of 13-year-olds compared with 16.5% of 15-year-olds in the 2015 SALSUS (personal communication – Scottish Government; (Scottish Government, 2016d)).

Figure 1.4: Proportion of 15-year-old pupils who reported having used cannabis in their lifetime and in the last year in England and Scotland, 2004 to 2016



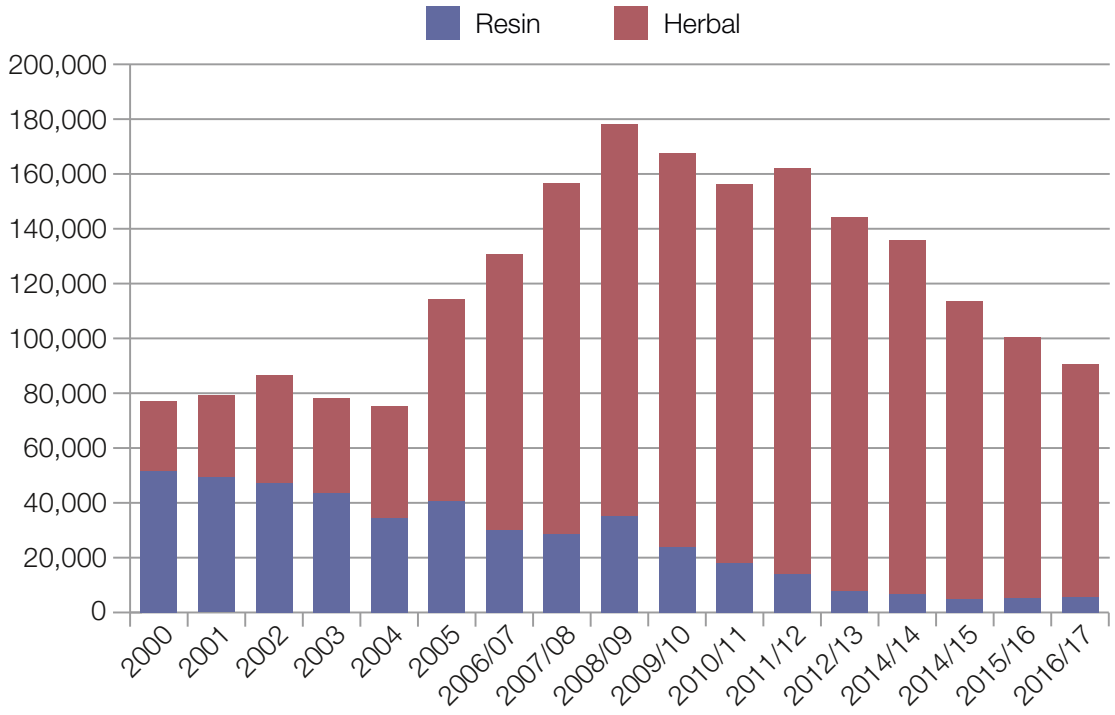
Source: (NHS Digital, 2017b; Scottish Government, 2016d); Accompanying table 1.10

1.3.2 Type of cannabis used

GPS do not currently report on the use of herbal cannabis versus cannabis resin. The CSEW previously showed that in 2009/10 71% of last year cannabis users used herbal cannabis and 38% used resin (Home Office, 2010a); however, there are indications that the market has shifted since then. Seizures data provides insight into the relative prevalence of these forms of cannabis in the UK market over time. In 2000, 67% of cannabis seizures made by police forces in England and Wales involved resin (Home Office, 2010b). The proportion of seizures involving herbal cannabis has since greatly increased, and in 2016/17 accounted for 94% of cannabis seizures (excluding cannabis plant seizures) (see Figure 1.5) (Home Office, 2016c).

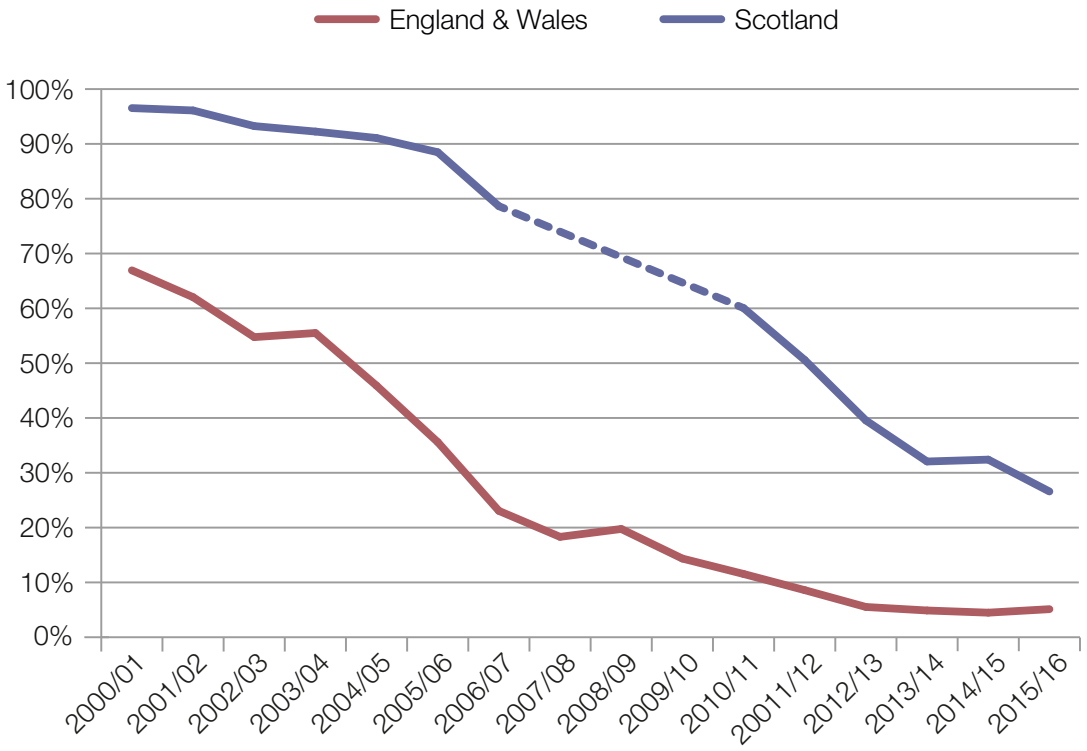
Scottish seizures data has also shown a long-term shift away from resin to herbal cannabis, although seizures of cannabis reported for Scotland have consistently shown a higher proportion involving resin than in England and Wales, as seen in Figure 1.6. Whereas 67% of cannabis seizures made by police in England and Wales in 2000 involved resin, the equivalent proportion in Scotland reported for 2000/01 was 97%. By 2015/16, the proportion of seizures involving resin in Scotland had decreased to 27% (Scottish Government, 2017a); however, this was considerably higher than the figure for England in the same year (5.1%) (Home Office, 2017b).

Figure 1.5: Number of herbal cannabis and cannabis resin seizures made by police forces in England and Wales, 2000 to 2015/16



Source: (Home Office, 2010b, 2017b)

*Figure 1.6: Proportion of the number of police cannabis seizures made up by cannabis resin, in England & Wales and Scotland, 2000/01 to 2015/16**



*Data for Scotland is not available between 2006/07 and 2010/11

Source: (Home Office, 2010b, 2017b; Scottish Government, 2008b, 2012a, 2013b, 2014a, 2015a, 2017a)

1.3.3 Treatment demand and hospital admissions

Despite the reduction in cannabis use seen in GPS since around 2003/04, the number of treatment presentations where cannabis was cited as the primary problematic substance has risen over the same time period (see section 4.2.2). There is no universally agreed explanation for the divergence of these trends, although one possibility is that while fewer people are using cannabis, those who are using it are experiencing greater harm and, as such, are more likely to seek treatment. In 2016, just over one-quarter of all treatment presentations in the UK were for primary cannabis use (see accompanying table 3.1). The pattern is starkly different for young people (under the age of 18) in drug treatment, with 91% citing cannabis as the primary drug bringing them into treatment (Public Health England, 2017o).

Cannabis potency data, giving information on the concentration of tetrahydrocannabinol (THC), is not reported for the UK; however, potency of both cannabis resin and herbal cannabis has increased over the past decade in Europe, which is the source of a significant proportion of the cannabis used in the UK (European Monitoring Centre for Drugs and Drug Addiction, 2017). This increase in potency among all forms of cannabis, a decrease in the THC to cannabidiol ratio of cannabis, and the increased dominance of high potency herbal cannabis within the UK market are all possible reasons why increased harm from cannabis use could occur. Freeman and Winstock, publishing on findings from the Global Drug Survey, found that high potency herbal cannabis was far more commonly associated with negative effects such as memory loss and paranoia than other types of cannabis, despite being the most popular form with respondents to the survey (Freeman & Winstock, 2015). Di Forti et al found far greater risk of first episode psychosis among those using high potency cannabis versus hash users (Di Forti et al., 2015).

1.3.4 Legal framework

Cannabis is one of two illicit drugs that can be dealt with using out-of-court disposals for simple first and second possession charges in England and Wales. Penalties can be in the form of official warnings or a fine (Her Majesty's Government, 2001a, 2009) (see section 8.3.1).

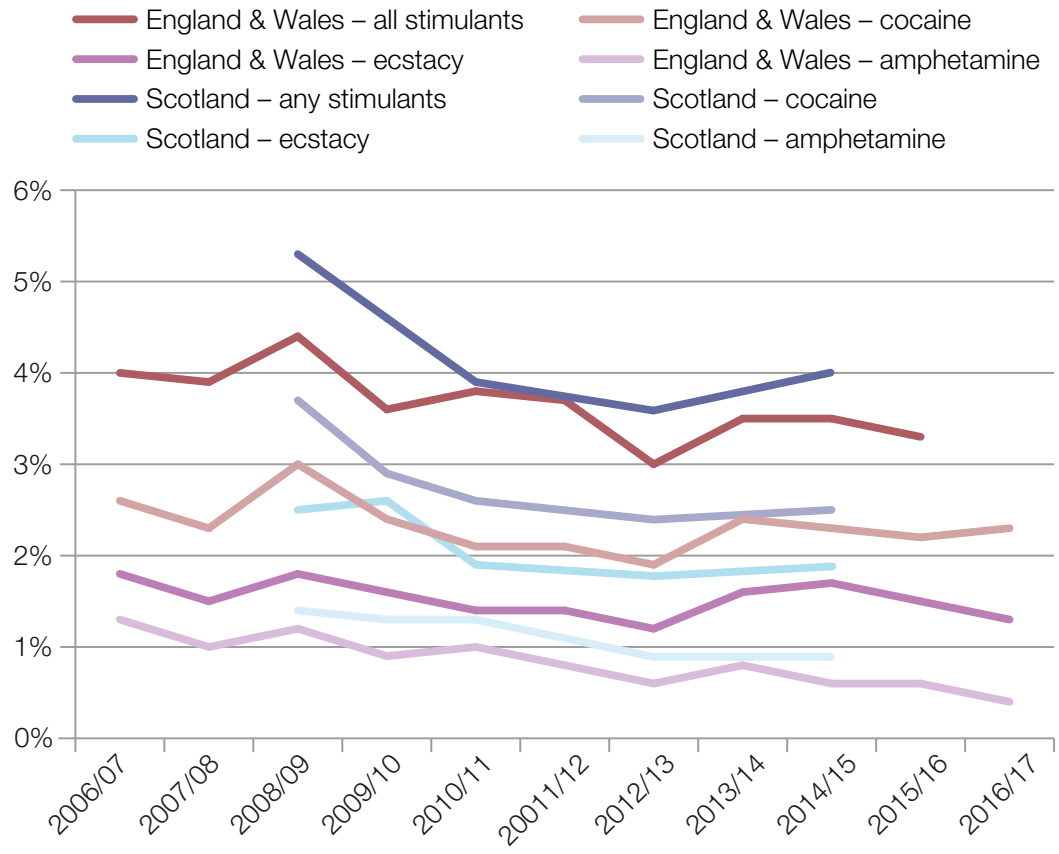
1.4 Stimulants

1.4.1 Overall prevalence of stimulant use

There has been a small, long-term, downward trend in the overall use of any stimulant drug[3] among 16-59 year-olds reported in the CSEW since the beginning of the time series, from 4.4% in 1996 to around 3.5% in recent years (see Figure 1.7). Last year use of any stimulant drug among all adults in the CSEW was significantly lower in 2015/16 than in 2005/06, having decreased from 3.9% to 3.3% (Home Office, 2016a). Last year stimulant use was not asked about in the 2016/17 CSEW. There was a decrease in the proportion of 16-59 year-olds using stimulants in the previous year in Scotland between 2008/09 and 2014/15, falling from 5.3% to 4.0% (Scottish Government, 2011, 2016c).

3 'Any stimulant drug' comprises powder cocaine, crack cocaine, ecstasy, amphetamines and amyl nitrite plus methamphetamine since 2008/09 interviews and mephedrone since 2010/11 interviews. Due to the inability of the survey to distinguish between stimulant and non-stimulant NPS, the CSEW did not report on the use of 'any stimulant drug' in 2016/17

Figure 1.7: Percentage of respondents to prevalence surveys in England & Wales and Scotland reporting last year use of all stimulants, powder cocaine, ecstasy and amphetamine, 2006/07 to 2016/17*



*Scottish data is for 16-59 year-olds rather than for all adults, as published in the SCJS headline figures. England and Wales data is for 16-59 year-olds

Source: (Home Office, 2016a, 2017a; Scottish Government, 2016c)

The reduction in the prevalence of stimulant use over time is also apparent in surveys of schoolchildren, although it has slowed in recent years. The proportion of pupils aged 11 to 15 in England reporting use of stimulants in the last year decreased from 6.9% in 2007 to 2.1% in 2014 according to the SDD; however, this figure increased in 2016 to 2.7% (NHS Digital, 2017b).

1.4.2 Powder cocaine

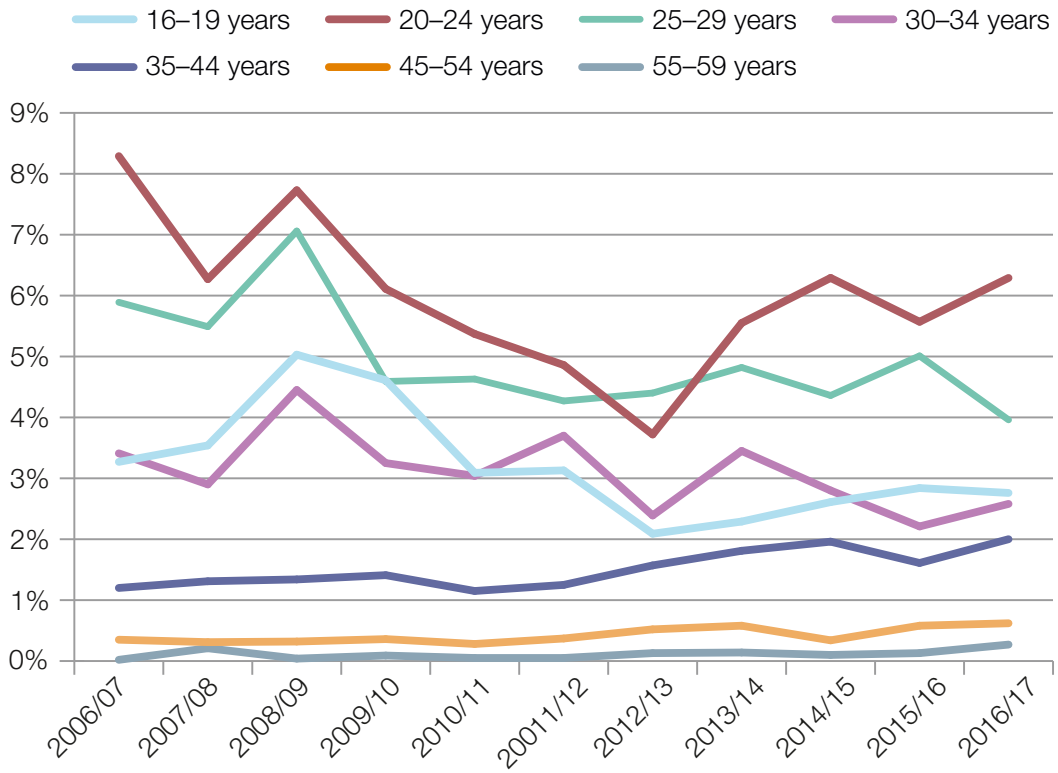
Prevalence of use

Powder cocaine is the most prevalent stimulant used in the UK and the second most prevalent drug overall, with last year use reported at 2.3% in England and Wales, 2.5% (among 16-59 year-olds) in Scotland, and 1.8% in Northern Ireland in the most recent surveys available (Home Office, 2017a; National Advisory Committee on Drugs and Alcohol & Department of Health Northern Ireland, 2016; Scottish Government, 2016c). Although varying methodologies and sampling techniques place limitations on the comparability between surveys, data reported in 2016 (from the 2015/16 CSEW) suggests that prevalence of cocaine use among adults in the UK was the highest of all European countries where figures were available (European Monitoring Centre for Drugs and Drug Addiction, 2017). Analysis of wastewater in a selection of European cities suggests London consumes a relatively large amount of cocaine.[4]

4 See: http://www.emcdda.europa.eu/topics/pods/waste-water-analysis#panel2

Since 2008/09, an overall fall in the prevalence of cocaine use has been reported in the CSEW (see Figure 1.7) (Home Office, 2017a). This appears to have been driven by lower levels of use in younger age groups, suggesting there were fewer initiates among this generation; however, prevalence among those aged under 35 appears to have stabilised in the past two years. Use among the 35-44 age group has increased over the past decade, as has use in those aged 45 and over, although to a smaller degree (see Figure 1.8). This may indicate that a greater proportion of people from older generations are continuing to use cocaine as they transition into middle age than was the case among those born ten years earlier.

Figure 1.8: Prevalence of last year cocaine use in England and Wales, by age group, 2006/07 to 2016/17



Source: (Home Office, 2017a)

Data from the most recent surveys indicate that last year use of cocaine powder was similar between 15-year-old pupils in England and Scotland, at 2.9% and 3.5%, respectively (NHS Digital, 2017b; Scottish Government, 2016d). Additionally, there has been a sharp increase in lifetime powder cocaine use among 15-year-olds in both countries. In England, lifetime prevalence of powder cocaine use increased from 2.3% in 2014 to 3.6% in 2016, while in Scotland, the proportion of 15-year-old pupils reporting lifetime use of powder cocaine nearly doubled between 2013 and 2015, from two per cent to 3.9% (see accompanying table 1.10) (Health and Social Care Information Centre, 2015; NHS Digital, 2017b; NHS National Services Scotland, 2014). Powder cocaine use is lower in Northern Ireland than in the other countries of the UK, with 0.6% of YPBAS respondents reporting ever using the drug in the 2016 survey (Northern Ireland Statistics and Research Agency, 2017b).

Seizures and purity

Powder cocaine is the most seized stimulant in the UK, both in terms of number and quantity of seizures (see section 9.4.1). The number of powder cocaine seizures has seen a small decrease since 2010 but has generally remained stable at around 20,000 per year since then. However, the 4,317 kg of cocaine powder seized in 2015/16 was the highest seen in the last decade.

Having been 51% in 2003, the mean purity of powder cocaine at user-level fell to 20% in 2009, but has risen since, and was 54% in 2016 (see section 9.3.5).

Treatment

During 2016, 12,466[5] individuals presented to treatment with a primary substance of powder cocaine across the UK (see accompanying table 3.1). Retrospective trends on English treatment data since 2005 show that the proportion of those presenting to treatment with a primary drug of powder cocaine increased between 2005 and 2008, from 6.2% to 10.1%. This proportion has remained relatively stable since, although the proportion in 2016 (11.0%) was the highest value in the time series. There were 4,607 clients in treatment at the start of 2016[6] in England with a primary substance of powder cocaine, comprising 3.5% of the treatment population at the start of the year (see accompanying table 3.9).

Indicators of harm

Drug-related deaths registered in England and Wales with cocaine mentioned on the death certificate (but not necessarily implicated) have risen year-on-year from 112 in 2011 to a record high of 371 in 2016 (Office for National Statistics, 2017a). This followed a fall in the number of deaths, from 235 in 2008. However, this trend broadly reflects that seen for heroin-related deaths and may to an extent be an artefact of the high prevalence of crack cocaine use among heroin users, as drug-related deaths data does not distinguish between those using powder cocaine and crack cocaine (see section 1.5.1). The number of deaths where cocaine was reported has also increased in Scotland in recent years, from 31 in 2012 to 123 in 2016 (see section 6.5.2) (National Records of Scotland, 2017).

1.4.3 Crack cocaine

Prevalence of use

Use of crack cocaine is far less common among the general population than use of powder cocaine. Although crack cocaine use is relatively rare, it is associated with very problematic use and crime, predominantly among those also using opioids. Due to the often chaotic nature of users' lives, it is likely that household surveys underestimate crack use. The most recent study to indirectly establish the size of the crack-using population in England in 2014/15 estimated that there were 182,828 (95% confidence interval (CI): 176,675 – 190,782) crack cocaine users in England, putting the rate at 5.21 (CI: 5.03 – 5.43) individuals per 1,000 population aged 15-64 years (Hay et al., 2017) (see accompanying table 2.3). This represented a statistically significant 10% increase from the estimate for 2011/12 of 166,640, and an increase in the rate per 1,000 population from 4.79 per 1,000 population of the same age (Hay, Rael dos Santos, & Worsley, 2014).

Injecting drug use

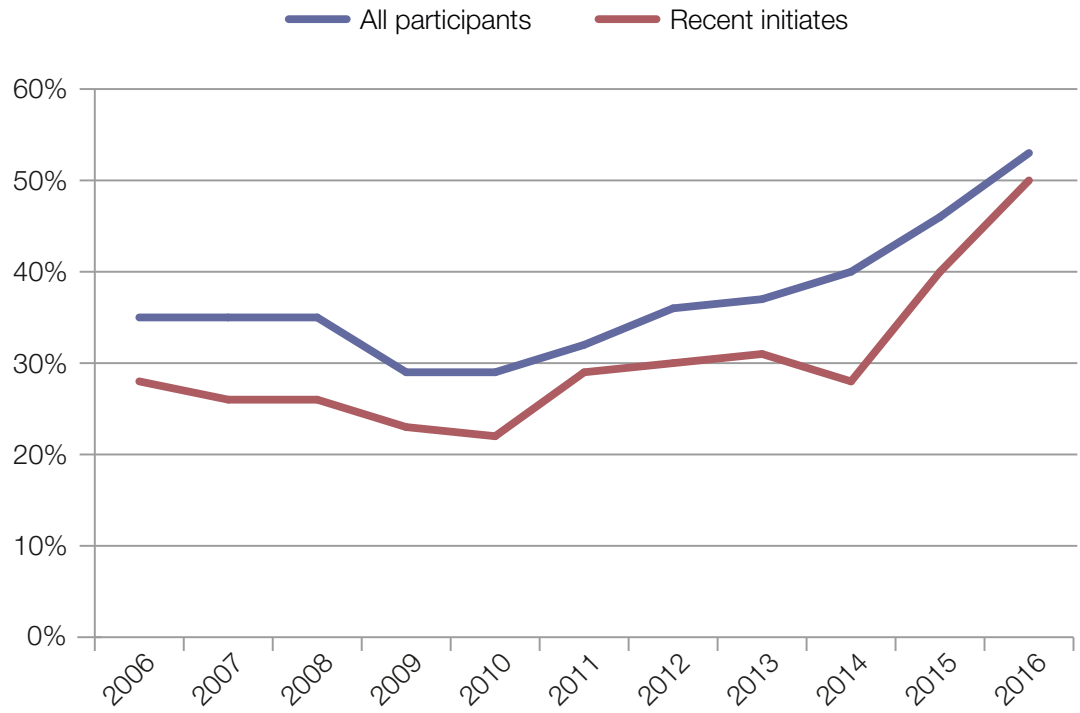
Data from the Unlinked Anonymous Monitoring survey (UAM) of people who inject drugs (PWID) indicates that injection of crack has increased in recent years in England and Wales, with 53% of those who had injected during the preceding four weeks reporting crack injection in 2016, as compared to 35% in 2006 (see Figure 1.9) (Public Health England, 2017e). Increases in crack injection were noted in Wales as well as multiple regions in England (East of England, London, South East, South West, and East Midlands), while no crack injection was reported in Northern

5 Includes clients presenting to treatment in the community throughout the UK, and those presenting to treatment in prisons in England, Scotland and Northern Ireland

6 Refers to those that were in treatment services at the beginning of the calendar year

Ireland in 2016. There was also an increase in the proportion of recent initiates to injecting (that is, those that started injecting within the past three years) reporting injecting crack, with 50% of recent initiates who had injected in the preceding four weeks reporting crack injection in 2016, compared with 28% in 2006. These relatively high rates of crack cocaine injection have not been found in Scotland: according to the most recent Needle Exchange Surveillance Initiative (NESI) data, only three per cent of respondents in 2015/16 reported injection of crack cocaine use in the last six months compared to 13% reporting powder cocaine injection (see section 7.5.2) (Health Protection Scotland, 2017b).

Figure 1.9: Proportion of all individuals and recent initiates that had injected drugs in the past four weeks participating in the Unlinked Anonymous Monitoring Survey in England, Wales and Northern Ireland that had injected crack cocaine, 2006 to 2016*



*Recent initiates are those that began injecting in the last three years

Source: (Public Health England, 2017e)

Seizures and purity

Crack cocaine purity has increased substantially over the last five years. In 2016, the average purity of user-level crack cocaine was 71%, up from 48% in 2015, having been as low as 26% in 2011, while the price has remained relatively stable (see section 9.3.3 and section 9.3.5). This increase in purity and ultimately affordability of crack cocaine may be related to the increase in the rate of crack cocaine use compared to previous years. As may be expected from the prevalence data, far less crack cocaine is seized compared to powder cocaine, with 46 kg and 4,317 kg of each substance being seized in the UK in 2015/16, respectively. Virtually all crack cocaine seizures in England and Wales are made by the police forces, reflecting the domestic nature of crack cocaine production from imported cocaine powder in the UK (see section 9.4.1).

Treatment

In 2016, 5,542 clients[7] presented to treatment in the UK with a primary substance of crack cocaine; 97% (n=5,362) of these clients presented in England (see section 4.3.2). Analysis of data from treatment presentations in the community in England shows that there has been a decrease in the number presenting with crack cocaine as their primary problem drug over time. The number of presentations to treatment peaked in 2008, when 7,184 primary crack cocaine clients presented, representing 7.2% of the treatment population. This decreased to 2,883 clients (3.6% of the treatment population) in 2015. However, similar to the number of seizures and estimate of crack prevalence, the number of clients entering treatment in England citing primary crack cocaine use increased between 2015 and 2016 (to 3,272 clients; 4.3% of the treatment population). The proportion of primary heroin treatment clients citing adjunctive use of crack cocaine has also increased, from 30.7% in 2005 to 53.8% in 2016 (see section 4.4.4).

1.4.4 Ecstasy/MDMA

Prevalence of use

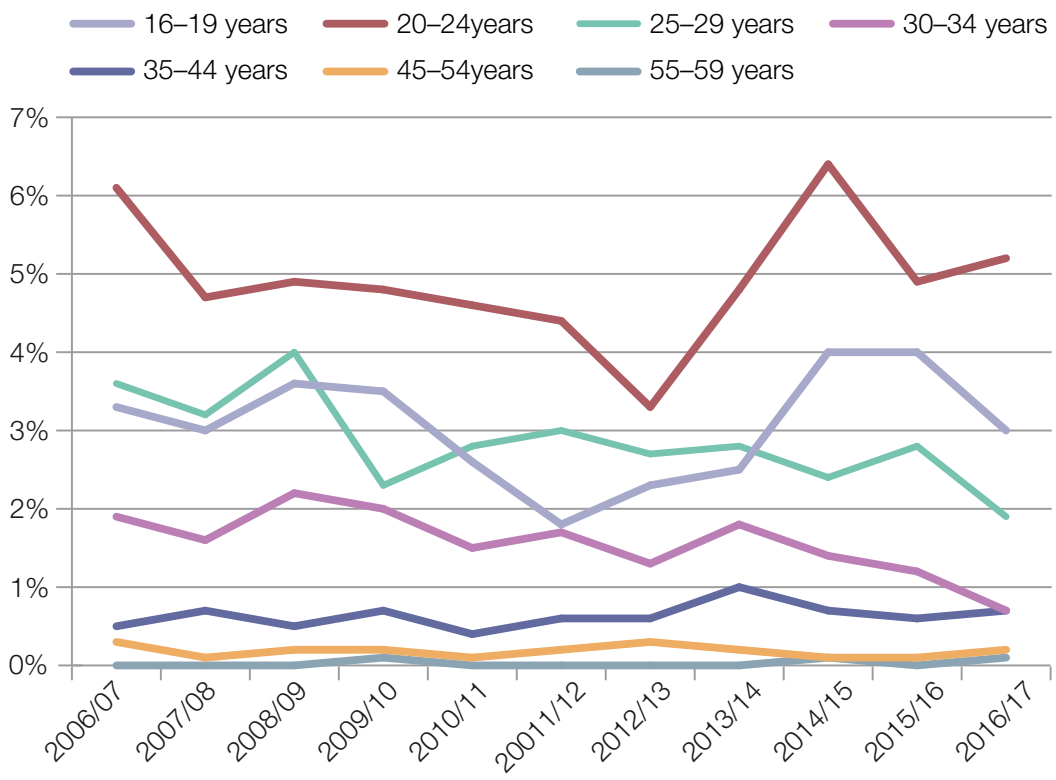
Ecstasy (MDMA) is the second most commonly reported stimulant from UK household surveys: last year use was reported as 1.3% in the 2016/17 CSEW; 1.9% (among 16-59 year-olds) in the 2014/15 SCJS; and 0.8% in 2014/15 in Northern Ireland (Home Office, 2017a; National Advisory Committee on Drugs and Alcohol & Department of Health Northern Ireland, 2016; Scottish Government, 2016c).

Prevalence of last year ecstasy use among survey respondents in England and Wales has fluctuated between 1.2% and 1.8% over the past decade, and has fallen from 2.6% in 2009/10 among 16-59 year-olds in Scotland (see Figure 1.7) (Home Office, 2017a; Scottish Government, 2016c). In England and Wales, prevalence among those aged under 25 reached a nadir in 2011/12 and 2012/13; however, use among the 16-19 and 20-24 age groups has now increased back to the level seen ten years ago. Use among the 25-29 and 30-34 years age groups has slowly declined over the past decade (see Figure 1.10) (Home Office, 2017a).

The proportion of last year ecstasy users reporting frequent use (that is, more than once a month) decreased from a peak of 20.2% in 2003/04 to 2.0% in 2012/13 (Home Office, 2017a). This proportion has increased slightly over the past five years, back up to 5.5% in 2016/17. The worldwide shortage of MDMA in the late 2000s (European Monitoring Centre for Drugs and Drug Addiction, 2016) leading to decreased availability in the UK market and users substituting with mephedrone or other NPS is one possible explanation for the decrease in frequent use, especially in relation to the fall between 2008/09 and 2009/10 from 13.9% to 5.5%. However, the current presence of high potency MDMA tablets and powder on the market (see seizures and purity section below) suggests that MDMA availability is no longer an issue, and the stabilisation of the proportion of frequent users at this lower level may be as a result of a change in user habits.

7 Includes clients presenting to treatment in the community throughout the UK, and those presenting to treatment in prison in England, Scotland and Northern Ireland

Figure 1.10: Prevalence of last year ecstasy use in England and Wales, by age group, 2006/07 to 2016/17



Source: (Home Office, 2017a)

The age profile for ecstasy users is younger than that for other stimulants, with 4.3% of 16-24 year-olds reporting last year use of ecstasy in the 2016/17 CSEW, and a greater proportion of 16-19 year-olds reported using ecstasy than cocaine in the last year in 2016/17 (3.0% compared to 2.8%) (Home Office, 2017a). While the likelihood of having used any of the most common stimulants in the last year increases substantially with the number of visits to nightclubs or to pubs/bars, this is particularly the case with ecstasy.

Among 15-year-old pupils in England, 4.0% reported ever using ecstasy in the 2016 SDD. The proportion was slightly higher among Scottish pupils, at 5.0% lifetime use in 2015 (NHS Digital, 2017b; Scottish Government, 2016d). Less than one per cent (0.8%) of YPBAS respondents aged 11-16 reported having ever using ecstasy in the 2016 survey (Northern Ireland Statistics and Research Agency, 2017b); in comparison, 1.5% of 11-15 year-olds in England reported having ever taken ecstasy in the 2016 SDD (NHS Digital, 2017b).

Seizures and purity

MDMA is sold in pill and powder/crystal form, with the powder form becoming more available following the decrease in potency of MDMA tablets in the late 2000s (Smith, Moore, & Measham, 2009). There was a very sharp fall in the number of ecstasy pills seized in England and Wales from 2006/07 to 2007/08, and the level has not yet returned to that seen before the drop (see section 9.4.1) (Home Office, 2017b). Data is not available on the quantity on MDMA seized in powder/crystal form.

Information from Europe indicates that the potency of MDMA tablets has increased in recent years. The mean dose of MDMA reported in 2016 was around 125 mg, compared to 50-80 mg seen in the 1990s and 2000s, and batches of very high potency tablets, for example containing up to 340 mg MDMA, have been identified (European Monitoring Centre for Drugs and Drug

Addiction, 2016). The Netherlands, which is the source country of the majority of MDMA tablets found in the UK market, has seen a shift in the proportion of tablets containing over 140 mg, from three per cent in 2009 to 53% in 2015. In 2016, the mean purity of MDMA powder at user-level in the UK was 75% (see section 9.3.5).

Indicators of harm

After having dropped sharply to a low in 2009 (coinciding with the global decrease in MDMA availability), deaths in England and Wales involving MDMA have since risen, with the number of deaths registered in 2016 (n=63) slightly higher than in the years before the drop (n=58 in 2005) (Office for National Statistics, 2016). There were seven deaths registered in Northern Ireland in 2016 involving ecstasy/MDMA, up from four the previous year. Scotland reported 28 deaths from ecstasy-type substances in 2016, an increase on 2015 (n=15) and high relative to its population (although this is a broader category than ecstasy alone reported elsewhere) (see section 6.5.2) (National Records of Scotland, 2017; Northern Ireland Statistics and Research Agency, 2017a).

1.4.5 Amphetamine

Last year prevalence of amphetamine use in England and Wales is now less than one-third of the level reported in the 2006/07 CSEW (Home Office, 2017a). Despite this decrease, amphetamines remain one of the most commonly reported classes of stimulants in surveys (last year use figures of 0.4% in the 2016/17 CSEW; 0.9% for 16-59 year-olds in the 2014/15 SCJS; and 0.5% in the 2014/15 Northern Ireland prevalence survey) (Home Office, 2017a; National Advisory Committee on Drugs and Alcohol & Department of Health Northern Ireland, 2016; Scottish Government, 2016c). Reported last year use of amphetamines[8] among 15-year-old pupils in England was lower than reported use in Scotland, at 0.5% and 2.0%, respectively (NHS Digital, 2017b; Scottish Government, 2016d).

Although amphetamine prevalence is lower than that of ecstasy, the number of amphetamine seizures in the UK is approximately one-and-a-half times the number of ecstasy seizures (see section 9.4.1). This may indicate that amphetamine users are more likely to come into contact with police, higher levels of consumption of amphetamine, and/or that amphetamine users (like crack and heroin users) are less well represented in household surveys than users of other drugs.

Average amphetamine powder purity at user level has remained steady for several years, ranging from five per cent to 12% between 2003 and 2016 (see section 9.3.5).

Retrospective trends show decreasing presentations to treatment in England for primary amphetamine use over the last decade: from 2006 to 2016 the number of treatment presentations fell from 3,418 to 1,513, representing a decrease in the proportion of all treatment entrants from 3.7% to 2.0% (see section 4.4.2). In 2016, there were 96 deaths registered in England and Wales where amphetamine was involved (Office for National Statistics, 2017a); in Scotland, 25 deaths were registered in 2016 where amphetamines were implicated in, or potentially contributed to, the cause of death (National Records of Scotland, 2017).

8 All listed youth surveys combine reports of amphetamine and methamphetamine use

1.4.6 Methamphetamine

Prevalence of methamphetamine use is low in the UK. Its use is mostly associated with men who have sex with men (MSM) involved in chemsex,[9] and in these instances it is often used alongside mephedrone and GHB/GBL. The incidence of injecting and other risky behaviours is high among this group, making this an area for concern. Recent anecdotal reports suggest that use of methamphetamine may have spread beyond this context and is being used at heterosexual chemsex parties and among other drug users; however, use remains low compared to the most common stimulants. Methamphetamine purity is high compared to that of other stimulants (75% at street-level compared with 54% for powder cocaine and 10% for amphetamine in 2016) (see section 9.3.5).

Although accounting for small numbers, a high proportion of methamphetamine users presenting to treatment in 2016 were recorded as current injectors (74/220; 33.6%) (see section 4.3.5). This adds to the on-going concerns about the injection of methamphetamine and mephedrone among sub-groups of MSM that participate in chemsex, many of whom are HIV positive. Chemsex often includes both injecting drug use and risky sexual behaviour, such as not using condoms, which can substantially increase the risk of transmitting infectious diseases. As such, the use and injection of these drugs has been reported to be a factor in the increased transmission of a number of sexually transmitted infections (Bourne, Reid, Hickson, Torres Rueda, & Weatherburn, 2014; Kirby & Thornber-Dunwell, 2013).

1.4.7 Mephedrone

Mephedrone is the only stimulant NPS to have become established alongside traditional substances among recreational drug users within the general population; however, prevalence has fallen since this substance was controlled in 2010. Having been 1.3% (akin to ecstasy) in the 2010/11 CSEW (the first year for which mephedrone prevalence was collected on the CSEW), last year use of mephedrone stood at 0.1% in England and Wales in 2016/17 (Home Office, 2017a). Last year prevalence of mephedrone use among 16-59 year-olds in Scotland was 0.5% in 2014/15, and was 0.6% in Northern Ireland in the same year (when last year use in England and Wales was reported at 0.5%) (National Advisory Committee on Drugs and Alcohol & Department of Health Northern Ireland, 2016; Scottish Government, 2016c). Like ecstasy, the age distribution of mephedrone users is younger than that of either cocaine or amphetamine. Because it is used by some problematic drug users, mephedrone prevalence reported by GPS may be an underestimate. Last year use of mephedrone among 15-year-olds in England was 0.7% in 2016, a decrease from 1.2% recorded in 2014 (NHS Digital, 2017b). Data on mephedrone use is not collected in the SALSUS.

Use of mephedrone is particularly of concern among MSM due to its association with chemsex (see section 1.4.6). In England, Wales and Northern Ireland, 4.4% (85/1,927) of those participating in the UAM survey during 2016 reported that they had injected mephedrone during the preceding year, which is a decrease from previous years (9.0% in 2014; 8.2% in 2015) (see section 7.5.2) (Public Health England, Health Protection Scotland, Public Health Wales, & Public Health Agency Northern Ireland, 2017).

9 Sexual activity, generally between men, under the influence of drugs taken immediately before and/or during a sex session to sustain, enhance, disinhibit or facilitate the experience and performance

1.5 Heroin and other opioids

1.5.1 Heroin

Heroin is the most commonly used illicit opioid in the UK. While drugs such as cannabis, powder cocaine and ecstasy are used by a larger proportion of the population, heroin is associated with causing the most health and social harm to users as well as harms to society in the form of drug-related crime. As such, heroin is of key importance to policy-makers in the UK.

Prevalence of use

As discussed in section 1.2.3, prevalence of heroin use is not accurately recorded by household surveys; instead, the size of the opioid-using population can be estimated using indirect statistical methods. In England, it was estimated that in 2014/15 there were 257,476 opioid users in England (Table 1.2), corresponding to a rate of 7.33 per 1,000 population aged 15-64 (Hay et al., 2017). In the same year, it was estimated that there were 22,600 long duration or regular users of opioids in Wales, corresponding to a rate of 11.54 users per 1,000 population aged 15-64 (Public Health Wales, 2015) (see accompanying table 2.2).

Table 1.2: Estimated number of problem opioid users, and rate per 1,000 population aged 15 to 64 in England, 2004/05 to 2014/15

Year	Number of problem opioid users			Rate per 1,000 population		
	Estimate	95% confidence interval		Estimate	95% confidence interval	
2004/05	281,320	279,753	292,941	8.53	8.48	8.88
2005/06	286,566	281,668	299,394	8.60	8.46	8.99
2006/07	273,123	268,530	283,560	8.11	7.98	8.42
2008/09	262,428	259,858	269,619	7.69	7.58	7.90
2009/10	264,072	260,023	271,048	7.70	7.58	7.90
2010/11	261,792	259,260	269,025	7.59	7.52	7.80
2011/12	256,163	253,751	263,501	7.32	7.25	7.53
2014/15	257,476	255,440	266,643	7.33	7.28	7.60

Source: (Hay, Gannon, Casey, & Millar, 2010, 2011; Hay et al., 2006, 2007; Hay et al., 2008; Hay, Rael dos Santos, & Millar, 2013; Hay et al., 2017; Hay et al., 2014)

Seizures and purity

A far greater quantity of heroin is seized each year in the UK than is seized of other opioids (see accompanying table 7.7). For the past four years, around 10,000 seizures of heroin have been made each year, down from 14,285 seizures made in 2010/11.

A number of indicators suggest that there was a lull in heroin availability from late 2010 through to 2012, with a large decrease in the purity of heroin seen during this time. In 2010, the mean user-level purity of heroin was 35%; this decreased to 18% in 2011, which was the year that supply was most impacted by the 'heroin drought'. In each following year, the purity of heroin increased, and was recorded at 43% in 2016. Falls in drug-related deaths and treatment presentations for primary heroin use were also seen during the early 2010s (see below); however, heroin-related deaths have now surpassed levels seen before the heroin shortage and are at an all-time high in the UK (see section 6.6.3).

Treatment

The number of people using heroin rose considerably during the 1980s and 1990s, and many of those currently using the drug started using around this time with fewer starting since. As such, the cohort of heroin users is ageing. Since 2005 the percentage of primary heroin users entering treatment in the community in England who were aged 35 years or over has doubled, from 29% to 62% in 2016, reflecting this trend (see section 4.4.3). However, the opposite trend has been found for young people (under the age of 18): in 2005/06, 881 (7.6%) young people in treatment cited an opioid (often heroin) as their primary substance, and by 2016/17 this number had dropped to 94 (0.7%) (see section 3.5.1).

Heroin users make up the majority of the population receiving structured drug treatment in the UK (see section 4.3.2). In 2016, 81% of the clients that were in treatment at the start of the year in England and Wales had reported an opioid as their primary drug, with 88% of these clients (71% of the total in continuous treatment) citing heroin. The vast majority of opioid clients (n=99,768; 89%) were currently receiving opioid substitution treatment (OST), with a further 7,927 opioid clients (7.0%) having received OST in the past (see accompanying table 3.10). Of the population that presented to treatment in the UK in 2016 (n=119,973), 49,232 presented for primary heroin use. Heroin was cited as an adjunctive drug in just four per cent of all cases, indicating that heroin is almost always seen as the most problematic substance for those who use it.

Although most individuals in long-term treatment are heroin clients, retrospective trends show that the number of people presenting for opioid use within each calendar year has decreased over the last decade. Since 2005, the proportion of treatment entrants in the community in England with an opioid as their primary drug has steadily decreased from 65% to 52% in 2016. This decline is even more prominent among first time entrants to treatment, where the proportion of primary opioid clients has more than halved, from 49% in 2005 to 18% in 2016.

Treatment and harm reduction interventions available for heroin and other opioid use include OST, needle and syringe programmes, blood-borne virus tests, foil provision, and take-home naloxone (see section 6.8 and section 7.6).

Indicators of harm

In the UK, under the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) definition, 2,656 deaths out of a total of 3,070 occurring in 2015 involved an opioid,[10] equating to 87% of the UK total. The proportion of deaths featuring an opioid reported through each General Mortality Register in 2015 was highest in Scotland (91%), followed by England and Wales (85% each), and Northern Ireland (84%) (see accompanying table 3.3).

Heroin contributes substantially to the UK's drug-related death figures. In England and Wales in 2015, according to the EMCDDA definition, there were 1,177 deaths featuring heroin, indicating that heroin was involved in almost 60% of all opioid-related deaths (n=1,989) and 51% of all drug-related deaths (n=2,329) (see section 6.5.2 for further information for each country). The median age of those dying from a drug-related death has also risen, and the ageing cohort of heroin users is thought to be a factor behind the long-term upward trend in deaths.

10 As the EMCDDA definition records deaths by year of occurrence, rather than registration, the most recent year for which there is sufficient data to report figures is 2015. See section 6.2 for further information

1.5.2 Methadone and buprenorphine

Prevalence of use

Medications prescribed in OST are sometimes diverted from the treatment system and, as such, methadone and buprenorphine also form part of the range of drugs used illicitly by the problem opioid-using population. Supervised consumption, the need for which is determined in accordance with clinical guidelines (Department of Health, 2017a), was introduced in the late 1990s and is an effective way of reducing diversion (Strang, 2010). Given both the source of supply and the population at risk of abusing them, diverted OST medications may be considered an adjunctive issue to the heroin problem. A negligible quantity of methadone is seized by Border Force, suggesting diversion from OST is the only significant source of illicitly used methadone in the UK.

Drug-related deaths figures from England, Scotland and Wales suggest there may have been an increase in use of diverted methadone during the 'heroin drought' between 2010 and 2012. This is in contrast to the drop in numbers accessing the treatment system over this period being prescribed this substance legitimately (see section 4.6 and section 6.6.3) (Home Office, 2015).

Treatment

Of the 57,673 clients in 2016 citing an opioid as their primary problem substance on entering treatment, four per cent cited that illicit methadone was their primary substance, and four per cent cited illicit buprenorphine (see accompanying table 3.1). Illicit methadone and buprenorphine were each cited by two per cent of all treatment entrants as adjunctive drugs. Buprenorphine use is more common among those in prison, particularly in Scotland. In 2016, of those presenting to treatment in prison in Scotland, 22% reported primary use of buprenorphine, compared to 1.7% of those presenting to treatment in other treatment centre types (see section 5.5.1).

Indicators of harm

There were 413 methadone-related deaths registered in England and Wales in 2016, approximately one-third of the number of deaths involving heroin/morphine (Office for National Statistics, 2017a). This represented 16% of the total number of drug misuse deaths.

1.5.3 Other prescription opioids

The misuse of opioids prescribed for pain-relief (for example tramadol and codeine) among the general population is a concern, particularly given the increasing practice of prescribing such medicines (Mordecai, Reynolds, Donaldson, & de C Williams, 2018); however, the UK is not considered to have a problem similar in scale to that of the USA (Advisory Council on the Misuse of Drugs, 2016b). While 7.6% of respondents to the CSEW in 2016/17 reported non-prescribed use of prescription-only pain-killers in the last year, only 0.2% had done so for the feeling it gave (as opposed to medical reasons) (Home Office, 2017a).

A number of indicators suggest that prescription opioid use is more prevalent in Northern Ireland than in the other countries of the UK. In the 2014/15 Northern Ireland prevalence survey, 10.0% of respondents reported having taken 'other opiates' (those other than heroin or methadone) in the last year, with 22.2% of respondents having ever taken these substances. In 2016, Northern Ireland also reported a relatively large proportion of its treatment entrants as seeking help for opioids other than heroin, methadone, buprenorphine and fentanyl (personal communication – National Drug Evidence Centre). Eleven per cent of treatment entrants (n=265) cited 'other opioids' as their primary substance, compared to 3.2% (n=3,893) in the rest of the UK. Codeine was cited as the primary substance by 105 clients in Northern Ireland (4.4% of all treatment

presentations in Northern Ireland), while tramadol was cited by 62 clients (2.6%) (see Table 1.3). In comparison, these substances were cited by 1.0% and 0.3% of treatment presentations in the rest of the UK, respectively.

Table 1.3: Number of clients presenting to treatment for 'other' opioids in the United Kingdom, by country, 2016

Drug	Country				
	England	Northern Ireland	Scotland	Wales	UK
Codeine	975	105	38	84	1,202
Dihydrocodeine	228	6	163	30	427
Tramadol	290	62	44	29	425
Unspecified/other opioids	1,500	39	111	136	1,786
Total	2,993	212	356	279	3,840

Source: Personal communication – National Drug Evidence Centre

Seizures from Northern Ireland make up a substantial part of the UK's total number of tramadol seizures. In 2015/16, Northern Irish police made 53 seizures of tramadol tablets, totalling 1,982 tablets. The total number of tablets seized in England and Wales in the same year was 6,418 tablets, just over three times the Northern Irish total (see accompanying tables 7.5 and 7.6).

The number of tramadol-related deaths has risen substantially in recent years; however, not all of these cases will relate to misuse of tramadol. The inclusion of such cases in official drug misuse death statistics is automatic due to the definition used, which counts any death involving a substance controlled under the *Misuse of Drugs Act 1971* (see section 6.2). However, tramadol is involved in a substantial proportion of drug-related deaths in Northern Ireland. Of the 126 drug-related deaths registered in 2016, tramadol was mentioned in 33 cases (26%) (Northern Ireland Statistics and Research Agency, 2017a); this was the highest number for any opioid (including heroin/morphine, which was involved in 25 deaths). In the same year, 7.1% (184/2,593) of drug-related deaths in England and Wales involved tramadol (Office for National Statistics, 2017a), while 7.4% (64/867) of drug-related deaths in Scotland mentioned this drug (National Records of Scotland, 2017).

1.5.4 Injecting drug use

Injecting drug use is associated with many harmful health outcomes, making injecting drug users a particularly important subset of drug users to monitor. Heroin remains the most commonly reported main injected drug across the UK. Data from the UAM survey of PWID showed that in 2016, 94% of those in England, Wales and Northern Ireland that reported injecting drugs in the past month injected heroin (Public Health England et al., 2017); in Scotland, 93% of those surveyed at services providing injecting equipment in 2015/16 who had injected drugs during the last six months reported injecting heroin (Health Protection Scotland, 2017b). The prevalence of stimulant (other than cocaine) injection had previously risen, with the proportion of PWID in England, Wales and Northern Ireland reporting injecting amphetamines and amphetamine-type drugs as their main drug in the UAM increasing from 3.9% in 2004 to 12% in 2014; however, this figure has since decreased to 5.7% in 2016 (Public Health England, Health Protection Scotland, Public Health Wales, & Public Health Agency Northern Ireland, 2015; Public Health England et al., 2017). The UAM indicates that injection of crack cocaine has increased in recent years in England and Wales (see section 1.4.3).

1.6 New psychoactive substances

1.6.1 New psychoactive substances (general)

Prevalence of use

Data from the 2016/17 CSEW showed that 2.4% of 16-59 year-olds in England and Wales reported ever taking an NPS, with 0.4% of 16-59 year-olds reporting having used an NPS in the past year, indicating a decrease from the 2015/16 survey (2.7% and 0.7%, respectively) (Home Office, 2017a). Those who reported using an NPS in the last year in the 2016/17 survey were asked what physical form the last NPS that they had taken was: 40% had most recently used a herbal smoking mixture; 19% had last used a powder, crystals or tablets; 12% had last used a liquid; and 30% had used another type of substance. Use of a herbal smoking mixture dropped from 52% in 2015/16; use of a liquid NPS increased from three per cent in the previous survey.

Prevalence of NPS use among the general population in Scotland and Northern Ireland is slightly lower than that seen in England and Wales. In 2014/15, 2.2% of adults aged 15-64 in Northern Ireland reported ever using an NPS (excluding mephedrone), and 0.3% reported last year use, compared to 2.8% and 0.8%, respectively, in England and Wales in the same year (Home Office, 2015; National Advisory Committee on Drugs and Alcohol & Department of Health Northern Ireland, 2016). The SCJS found that 2.2% of adults aged 16-59 had ever used an NPS or 'legal high' in 2014/15, and 0.5% had used one of these substances in the last year (Scottish Government, 2016c). Young people were more likely to have used NPS than older adults, with 4.2% and 4.1% of 16-24 year-olds in England & Wales and Scotland (respectively) reporting having ever used one of these substances in the most recent surveys (Home Office, 2017a; Scottish Government, 2016c).

In 2015, of all 15-year-old pupils asked in the SALSUS, five per cent reported that they had ever used an NPS, with two per cent reporting that they had used an NPS in the past month (Scottish Government, 2016d). By comparison, in the most recent SDD, 2.7% of 15-year-old respondents reported having ever used an NPS (NHS Digital, 2017b). The lowest reported lifetime use in the UK was reported in the 2015 YPBAS, where 0.4% of 11 to 16 year-old Northern Irish pupils reported having ever taken an NPS (excluding SCRAs and mephedrone) (Northern Ireland Statistics and Research Agency, 2017b); for comparison, in England, 2.2% of 11-15 year-olds reported having ever used an NPS (NHS Digital, 2017b).

Treatment

The English National Drug Treatment Monitoring System (NDTMS) has been recording the number of clients presenting to treatment with NPS use since 2013/14, when 144 clients presented to treatment with primary NPS use (Public Health England, 2014a). The most recent data shows that there were 2,528 clients in treatment in 2016/17 who reported use of NPS (both primary and adjunctive use), representing 1.3% of all clients currently in treatment for drug use. This was a slight decrease from 2015/16 (n=2,728) but approximately twice the number reported in 2014/15 (n=1,370) (Public Health England, 2015a, 2016a).

Indicators of harm

In recent years there has been an increase in the number of deaths where an NPS was recorded on the death certificate in the UK; this has been particularly evident in Scotland. In 2009, there were four deaths reported in Scotland where an NPS was involved; this increased to 112 in 2015, which tripled to 346 in 2016 (National Records of Scotland, 2017). Using the 'wide' definition, comparable to the ONS drug poisoning definition, NPS were involved in 35% (346/997) of all drug-related deaths in Scotland in 2016, more than double the proportion reported for 2015,

and more than ten times the proportion in England and Wales (Office for National Statistics, 2017a). Of the cases registered in Scotland in 2016, an NPS was implicated in, or potentially contributed to, the death in 286 cases. Benzodiazepine-type NPS were implicated in 277 of the 286 (97%) NPS-related deaths. Etizolam was implicated in 225 cases, and diclazepam was implicated in 75 cases (see section 6.5.2). The majority of benzodiazepine-type NPS deaths in 2016 also involved heroin, methadone, or both (n=230).

Legal framework

The *Psychoactive Substances Act 2016*, which came into force on 26 May 2016, prohibits the supply, production and trafficking of psychoactive substances (Her Majesty's Government, 2016c). The act was brought in as a response to NPS and the speed at which new substances emerge. Keeping pace with the NPS market presented a challenge using the existing legislation, as substances need to be added to the *Misuse of Drugs Act 1971* or included on a temporary class drug order (TCDO) in order to be controlled. The *Psychoactive Substances Act 2016*, however, controls all substances capable of producing a psychoactive effect except for a list of stated exemptions (see section 8.2).

1.6.2 Synthetic cannabinoid receptor agonists

Prevalence of use

When the CSEW asked about last year use of 'Spice' and other SCRAs in 2011/12, prevalence was low at 0.1% (Home Office, 2012). Although Spice has been removed from the CSEW, respondents who report having used an NPS are also asked what type of product they used on the last occasion. In 2016/17, 0.4% of all adults reported using an NPS in the past year; 40% of these individuals reported that the last NPS that they had used was a herbal smoking mixture (Home Office, 2017a). This indicates a reduction of use of these substances among the general population between 2015/16 and 2016/17, as both the percentage of adults using an NPS in the last year (0.7% in 2015/16) and the proportion using a herbal smoking mixture (52% in 2015/16) have decreased. This reduction in prevalence among the general population may be due to the introduction of the *Psychoactive Substances Act 2016* (see above).

In 2013, a question asking about the use of synthetic cannabinoids was included in the SALSUS. Two per cent of all the participants[11] in the survey reported having ever used a synthetic cannabinoid, similar to the proportion of pupils reporting ever using powder cocaine (Information Services Division, 2014b). This question was not included in the 2015 SALSUS (Scottish Government, 2016d). Use of SCRAs was asked about in the 2015 YPBAS, and it was found that 0.7% of respondents had ever used one of these substances (Northern Ireland Statistics and Research Agency, 2017b). This was similar to the prevalence of cocaine (0.7%) and ecstasy (0.8%).

As with heroin use (see section 1.5.1), SCRA prevalence may be underestimated by household surveys such as the CSEW, as use of these substances is believed to be particularly high among homeless and vulnerable people, and those in prison (see section 5.3.2). In Scotland, a recent survey attempted to establish the level of NPS use among a number of vulnerable or potentially at-risk groups, including PWID, mental health service users, vulnerable young people, homeless people and MSM (Scottish Government, 2016e). SCRAs were the most commonly used type of NPS in the survey population alongside benzodiazepine-type NPS (both reported by 41% of those who had used NPS in the past six months). SCRA use was particularly high among NPS users who were in contact with mental health services, homeless people, vulnerable young people, and PWID.

11 13- and 15-year-old pupils

Treatment

While not as common as some other traditional drugs of misuse, an increasing number of individuals in treatment are citing SCRAs as a problematic substance. Data from the English NDTMS showed that 1,369 clients in treatment in community settings during 2016/17 cited either primary or adjunctive problematic use of SCRAs (Public Health England, 2017a). This was a slight increase from the 1,277 clients who cited SCRAs as problematic in 2015/16 but more than double the 513 clients from 2014/15 (Public Health England, 2015a, 2016a).

Indicators of harm

Despite the apparently low prevalence of use and relatively low numbers of treatment presentations, in recent years SCRAs have caused concern in the UK with regard to hospital presentations. The UK National Poisons Information Service (NPIS) provides advice to healthcare professionals on the clinical management of potentially poisoned patients via telephone enquiries from the healthcare workers, or via the online database TOXBASE. In 2014/15, SCRAs were the class of drugs of misuse that were most enquired about to the NPIS, with 454 phone calls made to the service, compared to the next most commonly enquired about substance, cocaine, with 164 calls (National Poisons Information Service, 2015). This represented a large increase from 2011/12, when SCRAs were the 25th most common subject of telephone enquiries to the NPIS regarding drugs of misuse (National Poisons Information Service, 2012). However, the number of enquiries that the NPIS took about SCRAs decreased in 2016/17. The service took 51 phone calls about SCRAs, and 74 about branded products (which may include SCRAs) in this year, compared to 163 calls taken regarding cocaine (National Poisons Information Service, 2017).

The TOXBASE entry for SCRAs was the seventh most commonly accessed drug of misuse entry in 2016/17 with 3,166 accesses, a decrease of 34% from 4,770 accesses in 2015/16 (National Poisons Information Service, 2017). Therefore, while presentations to healthcare services by patients experiencing SCRA-induced toxicity are not uncommon, it appears that the overall number of presentations to healthcare services is decreasing.

SCRAs were involved in 27 drug-related deaths registered in England and Wales in 2016, a sharp increase from the 8 cases registered in 2015 (see section 6.5.2) (Office for National Statistics, 2017a).

Prison

SCRAs have become an established drug within prisons in the UK. Recent surveys have reported that SCRAs are now more prevalent than heroin, with around ten per cent of inmates reporting use of these substances in Her Majesty's Inspectorate of Prisons and Scottish Prison Service surveys (Her Majesty's Inspectorate of Prisons, 2015; Scottish Prison Service, 2015a). Other surveys have suggested a much higher prevalence of SCRA use, with one study reporting last month use of SCRAs at 33% among its respondents (User Voice, 2016). There have been many reports of serious harms, including deaths, associated with use of SCRAs in the prison setting (see section 5.4.1 and section 5.4.2).

Despite the overall prison treatment population being much smaller than those treated in the community, a greater number of those in treatment in prison cited SCRAs as problematic in 2015/16 (2,163 clients in secure settings compared to 1,277 clients in the community) (Public Health England, 2017k).

1.7 Other substances of interest

1.7.1 Benzodiazepines

Prevalence of use

Historically, problematic benzodiazepine use in the UK occurs predominantly in Scotland and Northern Ireland. The difference is pronounced enough that (as discussed in section 1.2.3) Scotland includes illicit use of benzodiazepines in their definition of problematic drug use. However, Northern Ireland has the highest rates of 'tranquiliser' use[12] in the UK: lifetime use is over 20% in Northern Ireland, but close to three per cent in England & Wales and Scotland (Home Office, 2017a; National Advisory Committee on Drugs and Alcohol & Department of Health Northern Ireland, 2017; Scottish Government, 2016c). Current use is also relatively high: Northern Ireland is the only country to have reported last month use of over 0.5% (at 7.2% in 2014/15). Poly-use of benzodiazepines and heroin is common (see treatment section below).

Seizures

In the UK in 2015/16, there were more seizures of benzodiazepines made than crack cocaine, amphetamines, or ecstasy (see accompanying table 7.5). The number of seizures has remained relatively stable over the past six years, with more than half of all UK seizures made by Police Scotland (4,082 of 6,701 benzodiazepine seizures in 2015/16) (Scottish Government, 2017a). A substantial proportion of seizures are also made in Northern Ireland: 655 seizures were made in this country in the same year, equating to approximately ten per cent of the total benzodiazepine seizures for the UK.

Treatment

The proportion of clients reporting problematic benzodiazepine use (both primary and adjunctive) upon presentation to treatment is considerably higher in Northern Ireland and Scotland compared to England and Wales. In 2016, the proportion of clients reporting problematic benzodiazepine use in Wales and England was close to ten per cent (11.3% and 7.1% respectively), compared to 21.7% in Scotland, and over one-third (33.4%) of treatment clients in Northern Ireland (see section 4.3.3). However, adjunctive use of benzodiazepines was more commonly reported than primary use across all countries, with three times as many clients presenting to treatment reporting benzodiazepines as an adjunctive problem as those reporting primary use. Almost two-thirds (65.6%) of adjunctive benzodiazepine cases in 2016 were clients who reported primary heroin use.

Indicators of harm

Benzodiazepines were associated with 406 deaths (16% of drug misuse deaths) registered in England and Wales in 2016, and benzodiazepine-type NPS were mentioned in ten cases (Office for National Statistics, 2017a). However, in the same year Scotland saw a similar number of benzodiazepine-related deaths (n=426), representing nearly 50% of all drug-related deaths in this country, and a continuation of the increasing trend (National Records of Scotland, 2017). Additionally, there were 278 benzodiazepine-type NPS-related deaths, accounting for nearly all of the NPS-related deaths in Scotland in 2016 (97%). Although Northern Ireland had a smaller number of deaths where benzodiazepines were involved (n=65) than Scotland, the percentage of benzodiazepine deaths was higher (59% and 49%, respectively) (Northern Ireland Statistics and Research Agency, 2017a). Across all countries of the UK, it was relatively uncommon for benzodiazepines to be the only drug mentioned on the death certificate (see section 6.5.2).

12 Northern Ireland reports tranquiliser use while England & Wales and Scotland report benzodiazepine use

1.7.2 Nitrous oxide

Use of nitrous oxide appears to have increased in the UK recently, in particular among young people. In the 2013/14 CSEW, 2.3% of 16-59 year-olds and 7.6% of 16-24 year-olds reported using nitrous oxide in the past year (Home Office, 2014). Nitrous oxide was included in the figures reported for all NPS in the 2016/17 CSEW (rather than being included as a separate category). Nitrous oxide use appears to be less common in Scotland, with 0.7% of adults aged 16-59 reporting use of this gas in the last year in the 2014/15 SCJS (Scottish Government, 2016c). Use of nitrous oxide was asked about in the SDD for the first time in 2016: 7.2% of 15-year-old respondents reported having used this substance in the past year (NHS Digital, 2017b). Use of nitrous oxide for its psychoactive properties is now prohibited by the *Psychoactive Substances Act 2016* (Her Majesty's Government, 2016c).

1.7.3 GHB/GBL

Prevalence of use

Use of GHB/GBL use was first asked about in the CSEW in 2009/10, and was removed from the CSEW in 2012/13 (Home Office, 2013). Prevalence of last year use was recorded at 0.1% in 2009/10 and 2011/12, and 0.04% in 2010/11. Young respondents to the survey were more likely to have used GHB/GBL, with last year use recorded at 0.5% in 16-24 year-olds in 2009/10 (Home Office, 2010a). Use of GHB/GBL is believed to be higher among MSM who may use this substance during chemsex (see section 1.4.6) (Abdulrahim, Whiteley, Moncrieff, & Bowden-Jones, 2016).

Indicators of harm

Deaths involving GHB/GBL in England and Wales increased from four deaths in 2005 to 30 in 2016, the highest number on record (Office for National Statistics, 2017a). Research carried out by forensic scientists in London identified 61 GHB-associated deaths occurring in the city between 2011 and 2015, with almost half (n=29) occurring in 2015 alone (Hockenhull, Murphy, & Paterson, 2017).

1.7.4 Image and performance enhancing drugs

Prevalence of use

The latest CSEW estimated that in 2016/17 lifetime prevalence of use of anabolic steroids among 16-59 year-olds was 1.1%, a slight increase from 2015/16 (0.8%), with last year prevalence at 0.2%, the same as in 2015/16 (Home Office, 2016a). Steroid use was similar in the 16-24 age group, with lifetime and last year prevalence at 1.0% and 0.4%, respectively, among these respondents. Prevalence of anabolic steroid use among adults (aged 15-64) in Northern Ireland in 2014/15 was comparable to results from the most recent CSEW, with 1.6% reporting lifetime use and 0.6% reporting last year use (National Advisory Committee on Drugs and Alcohol & Department of Health Northern Ireland, 2016). Scottish figures were substantially lower: according to the 2014/15 SCJS, 0.3% of respondents aged 16-59 reported lifetime use and 0.01% reported last year use (Scottish Government, 2016c). However, in comparison to adults, Scottish schoolchildren report higher prevalence of use, with 0.5% of 13-year-olds and 1.2% of 15-year-olds reporting use of anabolic steroids in the 2015 SALSUS (Scottish Government, 2016d).

Indicators of harm

A study conducted across England, Wales and Scotland in 2016 surveyed 684 image and performance enhancing drugs (IPED) users (94% of whom were male) regarding their IPED practices (Begley, McVeigh, & Hope, 2017). The survey found that the majority (85%) of participants have injected IPEDs, but oral IPEDs were equally, if not more, common (89%). The most commonly reported oral (methandrostenolone) and injectable (testosterone enanthate) IPEDs were both steroids. Of the respondents that reported injecting IPEDs, 18% reported reusing their own injecting equipment and 15% reported having shared a multi-dose vial. Thirty per cent of respondents had undertaken a test for hepatitis B in 2016; 28% reported having taken a test for hepatitis C in the same year; and 30% had been tested for HIV (see section 7.3, section 7.5.1 and section 7.6).

2 Drug policy

2.1 Introduction

Successive drug strategies published by the UK government and devolved administrations have cited considerable social and economic costs associated with drugs and the need to design policies aimed at reducing these costs. There is a well-established link between certain drugs and acquisitive crimes committed by dependent users to fund their drug use like shoplifting and burglary. On the supply side, drug gangs are often also involved in human trafficking, child exploitation and extreme violence. The harm to individuals is also recognised by policy-makers in the UK and a balanced approach is taken with the focus of policy being not just on enforcing drug laws but also on providing support to those who experience issues with dependence.

The UK government is responsible for setting the overall strategic approach to reducing drug harms and for its delivery in the countries of the UK in matters where it has reserved power. The *2017 Drug Strategy* (Her Majesty's Government, 2017a), as with the preceding strategy released in 2010, sets out its key aims of reducing drug use and increasing rates of recovery from dependence. Like the 2010 strategy, initiatives are arranged into themes of reducing demand, restricting supply and building recovery, with a new theme of global action introduced into the 2017 strategy.

In addition to the UK strategy, each of the devolved administrations has their own drug strategy, reflecting their respective approaches to addressing drug misuse. The Scottish government's and Welsh government's national drug strategies are both accompanied by an action or implementation plan, providing a detailed set of objectives, actions and responsibilities, expected outcomes and timescales for delivery (Scottish Government, 2008e; Welsh Assembly Government, 2008a, 2008b). Both the Welsh and the Northern Irish strategies cover actions aimed to reduce harms related to alcohol misuse as well as drug misuse (Department of Health Northern Ireland, 2011; Welsh Assembly Government, 2008a). The devolved administrations retain responsibility for ensuring the delivery of their own strategies.

2.2 Current national drug strategies and action plans

The legal framework relating to the misuse of drugs, including the *Misuse of Drugs Act 1971* (Her Majesty's Government, 1971), is reserved to the UK government (see section 8.2); however, some areas of policy including health, education, housing and social care are the responsibility of the devolved administrations.

2.2.1 United Kingdom

The *2017 Drug Strategy* (Her Majesty's Government, 2017a), published in July 2017, retains the two overarching aims that featured in the previous strategy (Her Majesty's Government, 2010) – to reduce drug use and increase rates of recovery from dependence – but enhances the measures on prevalence and recovery to reflect the greater ambition for progress against these aims. Building on the three core strands of the 2010 strategy – reducing demand, restricting supply, building recovery – the new strategy adds global action as a fourth.

The *2017 Drug Strategy* aims to:

- reduce demand by emphasising a whole-life approach to build resilience, as well as more targeted interventions to those that are particularly vulnerable to drug misuse
- restrict supply by taking co-ordinated action with partnerships on drug-related criminal activity, allowing flexibility in their methods to adapt to changing criminal activity patterns, and using technology and innovative approaches to data analysis and data utilisation
- build recovery by improving the quality of treatment and outcomes across user groups, ensure treatment options match the needs of clients, and improving the delivery of essential services often associated with drug use (such as employment and stable housing) to help support individuals to lead a drug-free life
- develop global action by acting in forward thinking ways on new initiatives such as responses to new psychoactive substances (NPS), promoting evidence-informed approaches to prevent drug-related harms, and sharing best practice guidance

For further information on the *2017 Drug Strategy*, see section 2.6.1.

The Home Office leads on the implementation of the strategy and with regard to reserved matters elsewhere, and is supported by various departments and organisations including the Department for Work and Pensions (DWP), the Department of Health and Social Care (DHSC), the Ministry of Housing, Communities and Local Government, the Department for Education (DfE), the National Crime Agency (NCA) and the Ministry of Justice (MOJ). A new Home Secretary-chaired Drug Strategy Board will maintain oversight of the delivery of the strategy. Treatment delivery is different across all countries with responsible organisations as follows: local authorities (LAs) and Her Majesty's Prison and Probation Service in England; community safety partnerships, local health boards, and area planning boards in Wales; alcohol and drug partnerships (ADPs) and NHS boards in Scotland; and the Public Health Agency and drug and alcohol co-ordination teams in Northern Ireland.

2.2.2 Scotland

The Scottish government's national drug strategy, *The Road to Recovery: A new approach to tackling Scotland's drug problem*, was published in 2008 (Scottish Government, 2008e), and received cross-party support from the Scottish Parliament. Central to the strategy is the concept of recovery and supporting people to live a drug-free life as active and engaged members of society. The strategy includes multiple objectives across five principal action areas: promoting recovery; delivering the recovery model; prevention; enforcement; and children affected by substance-misusing families.

The key priorities of the strategy are:

- better prevention of drug problems, with improved life chances for children and young people, especially those at particular risk of developing a drug problem, allowing them to realise their full potential in all areas of life
- to see more people recover from problem drug use so that they can live longer, healthier lives, realising their potential and making a positive contribution to society and the economy
- having communities that are safer and stronger places to live and work because crime, disorder and danger related to drug use have been reduced

- ensuring that children affected by parental drug problems are safer and more able to achieve their potential
- improving the effectiveness of delivery at a national and local level

To help achieve these goals, the Scottish government has developed an alcohol and drugs quality improvement framework to ensure quality in the provision of care, treatment and recovery services, as well as quality in the data that shows the outcomes people are achieving (see section 4.8.2) (Scottish Government, 2014b).

The *Updated Guidance for Alcohol and Drug Partnerships (ADPs) on Planning and Reporting Arrangements* (Scottish Government, 2015c) identifies nationally agreed core outcomes and indicators against which all ADPs are expected to deliver. The Scottish government has developed a Recovery Outcomes tool, designed to form part of the new national Drug & Alcohol Information System (DAISy), which aims to support the tracking of progress towards recovery for individuals in drug and alcohol services.

In July 2017, the Scottish Public Health Minister announced that the Scottish government intended to refresh the Scottish drug strategy in response to the changing nature of Scotland's drug problem. It is expected that the refresh will show strong connections to wider portfolios including justice, housing, employability and mental health. Work is also being undertaken to develop a 'Seek, Keep and Treat' framework which will examine the operational implications of engaging with increasingly older drug users, how to encourage them into using services, and how to retain them in treatment once they have engaged with services.

2.2.3 Wales

The Welsh government's strategy, *Working together to reduce harm 2008-2018* (Welsh Assembly Government, 2008a), combines drugs, alcohol, and addiction to prescription drugs and over the counter medications. It has a clear focus on reducing the harms associated with substance misuse, citing its four aims as:

- reducing the harm to individuals (particularly young people), their families and wider communities from the misuse of drugs and alcohol, while not stigmatising substance misuse
- improving the availability and quality of education, prevention and treatment services and related support
- making better use of resources: supporting evidence-based decision making, improving treatment outcomes, developing the skills base of partners and service providers by giving a greater focus to workforce development, and joining up agencies and services more effectively
- embedding the core Welsh government values of sustainability, equality and diversity, support for the Welsh language, and developing user-focused services and a rights base for children and young people in both the development and delivery of the strategy

Since the launch of the strategy, several accompanying shorter-term delivery plans have been published, the current version being *Substance misuse delivery plan 2016-2018* (Welsh Government, 2016), covering the last three years of the strategy. The delivery plans set out performance measures for each of the strategy's key action areas: preventing harm; supporting substance misusers to improve their health, and to aid and maintain recovery; supporting and protecting families; and tackling availability as well as protecting individuals and communities

via enforcement activity. Progress of the delivery plan is monitored through an internal cross-government Substance Misuse Programme Board, and an external Substance Misuse National Partnership Board which meets three times a year. The current plan highlights the importance of the substance misuse agenda in relation to the *Well-Being of Future Generations (Wales) Act 2015* (National Assembly for Wales, 2015) and covers both physical and mental wellbeing.

2.2.4 Northern Ireland

The first phase of Northern Ireland's current strategy, the *New Strategic Direction for Alcohol and Drugs* (NSD), was launched in 2006 with a focus on reducing the harms related to alcohol and drug misuse (Department of Health Northern Ireland, 2006). The strategy emphasised five supporting pillars: prevention and early intervention; treatment and support; law and criminal justice; harm reduction and monitoring; and evaluation and research. It identified two themes (children, young people and families; and adults, carers and the general public) to be addressed across the five pillars, as well as the three cross-sectional threads of workforce development, stakeholder involvement and vulnerable groups to run throughout the strategy.

The strategy was reviewed and revised before being relaunched in 2011 as the *New Strategic Direction for Alcohol and Drugs Phase 2*, *2011-2016* (Department of Health Northern Ireland, 2011). A number of key priorities were identified, including:

- developing a regional commissioning framework for treatment
- targeting those at risk and who are vulnerable
- addressing alcohol and drug-related crime including anti-social behaviour and tackling underage drinking
- reducing the availability of illicit drugs
- addressing community issues
- promoting good practice in respect of alcohol- and drug-related education and prevention
- developing harm reduction approaches
- workforce development

The ongoing development and implementation of the drug strategy is overseen by the NSD Steering Group. The final review and evaluation of NSD Phase 2 is currently delayed due to the suspension of the Northern Ireland Assembly.

2.3 Themes in drug policy

2.3.1 Prevention

In line with the previous strategy, the UK government's *2017 Drug Strategy* mixes universal prevention actions aimed at all young people with targeted actions for those most at risk of using drugs or who have already started using drugs (Her Majesty's Government, 2017a). It sets out methods to tackle the risk factors that make people vulnerable to substance misuse, which include investing in a range of evidence-based programmes that have a positive impact on young people and adults, giving them the confidence, resilience and risk management skills to resist drug use and recover from set-backs.

The emphasis on preventative initiatives for young people found in the UK drug strategy is also reflected in the strategies and other policy documents from the devolved administrations. In Wales, this is formalised through the *Rights of Children and Young Persons (Wales) Measure 2011* (Welsh Government, 2011) as well as *Working Together to Reduce Harm Substance Misuse Strategy Annual Report – 2015* (Welsh Government, 2015c), which recognises the importance of identifying young people at risk of engaging in risky behaviours as early as possible as a key aspect of prevention.

The Getting It Right For Every Child programme provides guidance on delivering Scotland's three social policy frameworks – the *Early Years Framework; Achieving our Potential*; and *Equally Well* (Scottish Government, 2008a, 2008c, 2008d) – that aim to develop the early intervention agenda. A guide to the programme for practitioners involved or working with children and young people was published in 2012 (Scottish Government, 2012b). More recently updated practice guidance, *Getting Our Priorities Right* (Scottish Government, 2013c), was developed for agencies and practitioners working with children, young people and families affected by substance use in Scotland.

In Northern Ireland, *Our Children and Young People – Our Pledge: A 10 year strategy for children and young people in Northern Ireland, 2006-2016* (Office of the First Minister and Deputy First Minister for Northern Ireland, 2006) sets out a framework for addressing the needs of young people. Improved education and early interventions for young people and families (especially those most at risk) and improved public information about drugs are priority areas. A consultation on the upcoming strategy, *Children and Young People's Strategy 2017 – 2027*,[13] was concluded in March 2017; the results have not yet been published.

2.3.2 Treatment

United Kingdom

The UK *2017 Drug Strategy* (Her Majesty's Government, 2017a) notes that progress has been made in supporting people to recover from their dependence on drugs since the publication of the previous drug strategy in 2010 (Her Majesty's Government, 2010), but states that the government needs to go further by enhancing treatment quality and improving outcomes through tailored interventions for different user groups. Treatment remains at the heart of the strategy, with one of its two core aims being to increase the rate of individuals recovering from their dependence (the other being to reduce illicit and harmful drug use). Previously, this was measured by calculating the proportion of clients leaving treatment free from dependence and not returning for six months; the strategy announced that this measure will now capture those that are still free from dependency at 12 months.

Within the strategy, an emphasis is placed on the importance of community treatment services collaborating with other services that may be in contact with individuals who have drug and/or alcohol problems. The government also notes that treatment services need to improve collaboration with mental and physical health care, employment services and the criminal justice system. The strategy states that the government will:

- encourage more effective, joined-up commissioning
- bring support from Public Health England (PHE) to local areas to ensure the best possible outcomes are being achieved
- share guidance and best practice of effective commissioning across multiple agencies

13 See: https://www.education-ni.gov.uk/consultations/children-and-young-peoples-strategy-2017-2027

- make data on outcomes (against a new, broader set of indicators) publicly available and easily accessible, allowing local areas to be held to account

The strategy also discusses the importance of quality assurance, with commissioners being guided to support and develop quality governance structures for drug treatment.

England

The Public Health Outcomes Framework[14] (Department of Health, 2012) set out the government's strategic direction in meeting two high level objectives: to increase healthy life expectancy; and to reduce differences in life expectancy and healthy life expectancy between communities. The framework includes indicators and sub-indicators which are explicitly related to drugs: reporting the proportion of successful completions of treatment for opioid and non-opioid users who do not return within six months, and reporting the number of deaths related to drug misuse; and reporting the proportion of adults with substance misuse treatment need who successfully engage in community-based structured treatment following release from prison.

Scotland

The concepts of recovery and supporting people to live a drug-free life as active and engaged members of society are central to the Scottish government's drug strategy (see section 2.2.2) (Scottish Government, 2008e).

The key treatment-related priorities of the strategy are: to see more people recover from problem drug use so that they can live longer, healthier lives, realising their potential and making a positive contribution to society and the economy; and to improve the effectiveness of delivery of treatment at a national and local level.

The Scottish government has developed a Recovery Outcomes tool[15] for use by local services to record and monitor people affected by problem drug and alcohol use. This is a peer-reviewed tool which has been developed through consultation with ADPs, drug and alcohol frontline staff, managers, service users and research groups.

The key aim of the tool is to measure changes in a person's life that may occur when they receive an intervention from specialist drug and/or alcohol services in Scotland. This tool will help to provide a better understanding of an individual's recovery journey, related needs and motivation for change. Secondary benefits of the outcomes measurement tool are to inform workforce development, service improvement and future service provision for managers, ADPs, funding bodies and the Scottish government.

Wales

The treatment-related objectives of the Welsh government's substance misuse strategy (Welsh Assembly Government, 2008a) include:

- improving the availability of treatment services and related support
- making better use of resources – using evidence-based decision making, improving treatment outcomes, developing the skills of those working in the treatment sector and promoting joined up working across agencies
- developing user-focused services

14 See: http://www.phoutcomes.info/

15 See: http://www.ssks.org.uk/topics/drugs-and-alcohol/recovery-outcomes.aspx

The strategy has been accompanied by shorter-term implementation plans which outline performance measures for each of the key action areas, including supporting substance misusers to improve their health and aid and maintain recovery. Establishing recovery-oriented systems of care, peer-led recovery community support, and implementing best practice across Wales continue to be prioritised.

Northern Ireland

The NSD Phase 2 was developed on the basis of five pillars which include a treatment and support pillar to address the long-term objective of providing accessible and effective treatment for those who use drugs in a potentially harmful way (Department of Health Northern Ireland, 2011). This pillar acknowledges the importance of providing a comprehensive range of community oriented and evidence-based treatment, rehabilitation and aftercare services for those misusing substances and their families. As part of a comprehensive plan, approaches to treatment should be multi-disciplinary and should have clear care pathways in place that include throughcare, aftercare, reintegration and recovery.

To meet the treatment and support long-term objective, the current Northern Ireland strategy has a number of treatment-related priorities including:

- developing a regional commissioning framework for treatment
- targeting those who are at risk and vulnerable
- workforce development

2.3.3 Drug users in prison and the broader criminal justice system

England and Wales

2017 Drug Strategy

The *2017 Drug Strategy* (Her Majesty's Government, 2017a) dedicates a section to prisons within the restricting supply chapter (one of the four key themes of the strategy). The strategy refers to the increased use and trade of illicit drugs within the prison estate seen over the past few years, and discusses the safety and security measures outlined in the *Prison Safety and Reform* white paper (Ministry of Justice, 2016b) (see below). To improve the response to the increased prevalence of drug use in prisons, the strategy states that the government will strengthen key existing measures, in order to:

- enhance the current drug testing regime
- improve the prison drug search capability
- ensure the perimeters of prisons are secure
- introduce legislative changes to add psychoactive substances to the list of items that it is a criminal offence to smuggle into prison

The strategy also discusses the programme of prison reforms that the government is currently undertaking. As part of these reforms, prison governors, along with health commissioners, will be responsible for commissioning and delivering healthcare services (including drug treatment programmes), being involved in the decision-making process at every stage of the commissioning cycle. Governors will therefore be held to account for the outcomes of these programmes, and the government states that they will introduce measures of success for substance misuse outcomes.

The government also listed a number of existing measures for tackling the supply and demand for psychoactive substances that they will reassess in due course. These include:

- the substance misuse treatment pathway for prisoners, and how services meet the treatment and recovery needs of offenders
- the role of prison officers in the provision of services
- drug treatment services to and from the community
- research to assess the relative effectiveness of current methods to tackle the supply of drugs
- the relationship between substance misuse and other issues, such as mental health

With regard to treatment in prison, the drug strategy discusses the introduction of the Health and Justice Information System by NHS England, intended to be used to evaluate the effectiveness of drug treatment systems in custodial settings. The government states that it will use this data, and the results from the Integrated Drug Treatment System evaluation, to identify and disseminate good practice to help improve outcomes in relation to prison-based drug treatment and the prevention of drug-related deaths (DRDs).

Prison Safety and Reform white paper

Reducing the supply of, and demand for, illicit items including drugs was included as a step towards improving prison safety and security in the MOJ's *Prison Safety and Reform* white paper, published in November 2016 (Ministry of Justice, 2016b). The paper discussed supply reduction measures that had already been introduced in the prison estate, including: the piloting of a body scanner at Her Majesty's Prison (HMP) Wandsworth to detect internally concealed contraband; training over 300 dogs to identify psychoactive substances in postal items and on individuals; and the introduction of nationwide mandatory testing for specific NPS, following a pilot in 34 prisons. The paper set out future responses to the current drug situation in prisons, including:

- enhancing the prison drug testing regime, supporting governors to enable drug testing on entry to and exit from prison, increasing the frequency and range of drugs tested for
- introducing legislation to simplify which psychoactive substances are covered by the existing testing process, allowing tests for substances appearing on the market to be introduced more swiftly
- changing legislation to make it a criminal offence to smuggle psychoactive substances into prison
- improving searching capability with dedicated search teams that can be deployed to target specific problem areas

The paper also described how the MOJ will reassess its existing strategy for tackling the supply and demand for existing and new controlled substances.

Scotland

Prison-based drug treatment programmes are highlighted in the Scottish drug strategy as a means of assisting recovery (Scottish Government, 2008e). Additionally, one of the key recommendations of the *Equally Well* strategy (Scottish Government, 2008d), which focused on health inequalities, was for offenders who want to tackle their drug problems to be able to access addiction and health services within six weeks of release from prison. Improving the health and wellbeing of offenders was also cited as a means to reduce inequalities associated

with violence and alcohol and drug problems. *Equally Well* was reviewed in 2010 (Scottish Government, 2010b), and it was agreed to continue offering Throughcare Addiction Services, which offer wraparound support to offenders with addiction issues who are being released from prison. This is a particularly important service, as recently released offenders have a significantly higher risk of fatally overdosing on drugs (particularly opioids) than the general population (see section 5.4.4) (Farrell & Marsden, 2008; Merrall et al., 2010).

The *Strategy framework for the management of substance misuse in custody* (Scottish Prison Service, 2010) reflects the aims and objectives of the Scottish government's national drug strategy. Over the past decade prison policy on managing prisoners with problematic substance misuse has moved from a punitive response to a therapeutic approach, offering a comprehensive integrated treatment service to support recovery and community integration and to reduce reoffending. The strategy focuses on robust security systems to divert, disrupt, detect and deter the supply of illicit substances and to support the provision of treatment services to encourage prisoners to reject the illicit drug culture.

NHS health boards have been responsible for the provision of health services in prison, including substance misuse and mental health services, since 2011. They provide a range of health and substance misuse services broadly comparable to that available in the community, with the emphasis placed on recovery-focused treatment options. An independent expert review of opioid substitution treatment (OST) in Scotland published in 2013 acknowledged the role that prison healthcare has to play in delivering OST to assist recovery (Drug Strategy Delivery Commission, 2013).

Northern Ireland

There is a concerted effort by the Northern Ireland Prison Service (NIPS) to address substance misuse based around a three strand approach: to restrict supply; to reduce demand; and to assist recovery.

In March 2012 NIPS and the South Eastern Health and Social Care Trust (SEHSCT), which is responsible for providing healthcare (including addiction services) in prisons, jointly published a *Strategic Framework for the Reduction and Management of Substance Misuse in Custody*. The framework provides strategic direction and guidance in the management of prisoners with substance problems. The strategic aims of the framework are to:

- reduce the availability and supply of illicit substances
- reduce the levels of substance misuse through recovery-based treatment programmes
- ensure treatment programmes are integrated with, not separate from, a wide range of related prison-based services
- develop substance misuse services to reflect the diverse needs of the prisoner population

NIPS and SEHSCT will take all reasonable measures to reduce the availability of illicit substances to prisoners, and provide services aiding recovery that are broadly equivalent to those available in the community, while recognising that prisoners require different routes to recovery.

NIPS also established a team to work in partnership with SEHSCT to address the recommendations from the Criminal Justice Inspection Northern Ireland report, *Safety of Prisoners held by the Northern Ireland Prison Service* (Criminal Justice Inspection Northern Ireland, 2014). This includes an examination of the strategy to manage substance misuse in prisons. NIPS and SEHSCT are currently in the process of revising the substance misuse policy and strategy.

2.3.4 Drug-related harms and harm reduction

United Kingdom

One of the overarching aims of the UK's *2017 Drug Strategy* is to reduce illicit and other harmful drug use (Her Majesty's Government, 2017a). Part of the strategy is aimed at providing a recovery-orientated treatment system where all services are commissioned with a range of best practice outcomes in mind, including the prevention of DRDs and blood-borne viruses (BBVs). The UK drug strategy recognises that drug treatment can be very effective in preventing negative outcomes for society and individuals, and that needle and syringe programmes (NSP) help to reduce certain harms caused by drug dependency, such as the spread of BBVs. Moreover, LAs have the flexibility to plan approaches to tackle drug misuse as part of a wider strategy to support public health-focused interventions.

Scotland

The Scottish government's drug strategy (Scottish Government, 2008e) outlines the expectation for harm-reduction services to be available in each part of Scotland. Such services provide NSP, sterile paraphernalia and advice to reduce BBVs such as HIV and hepatitis C.

Hepatitis C was identified as a serious risk to public health in 2004, resulting in the heavily invested Hepatitis C Action Plan for Scotland. This plan, in conjunction with an increase in the availability of substance use treatment, led to a decline in incidence of new hepatitis C cases by as much as half (Palmateer et al., 2014; Wylie, Hutchinson, Liddell, & Rowan, 2014). In 2011, separate policies on sexual health, HIV and hepatitis were brought in to a combined *Sexual Health and Blood Borne Virus Framework*. The latest framework (2015-2020) sets key priorities relating to hepatitis including prevention, testing and diagnosis, treatment and monitoring. The Scottish government is aiming for a 75% reduction in the number of people developing hepatitis C-related liver failure and cancer by 2020.

Wales

The Welsh government's substance misuse strategy predominantly focuses on reducing the harms associated with substance misuse (see section 2.2.3), with a key aim to reduce harm to individuals (particularly young people), their families, and the wider community without stigmatising drug users. Additional relevant guidance is provided in *Diagnostic Testing for Hepatitis C, Hepatitis B and HIV* (Public Health Wales, 2014a); *Blood Borne Viral Hepatitis Action Plan for Wales 2010–2015* (Welsh Assembly Government, 2010); and *Together for Health – Liver Disease Delivery Plan* (Welsh Government, 2015b).

The Welsh government also funds the Welsh Emerging Drugs and Identification of Novel Substances Project (WEDINOS)[16] which has been established to provide a framework for the collection and testing of NPS and combinations of drugs. This information is used to create drug profiles, which are shared online, that can be used to provide pragmatic harm reduction advice.

Northern Ireland

The NSD Phase 2 (Department of Health Northern Ireland, 2011) focuses on reducing the harms relating to drug and alcohol misuse. The overarching, long-term, drug-related objectives are to:

- reduce the level of drug-related harm to users, their families, their carers and the wider community

16 See: http://www.wedinos.org

- increase awareness, information, knowledge, and skills on all aspects of drug-related harm in all settings and for all age groups
- integrate those policies which contribute to the reduction of drug-related harm into all government policy
- develop a competent and skilled workforce across all sectors that can respond to the complexities of drug use and misuse

2.3.5 Restricting supply

Priorities for restricting drug supply outlined in the *2017 Drug Strategy* (Her Majesty's Government, 2017a) include:

- tackling the production and distribution of drugs (internationally and domestically)
- managing information and intelligence
- tackling enablers of criminality, for example dark net markets, corruption and money laundering
- tackling specific types of crime, such as drug driving and anti-social behaviour
- using health-based, rehabilitative interventions to address the drivers of crime

The UK *Serious and Organised Crime Strategy* (Her Majesty's Government, 2013) was published in October 2013 and coincided with the launch of the NCA. It reflects the changes to the threats the UK faces, and aims to substantially reduce national and international serious and organised crime. With regard to drugs, the strategy focuses on restricting supply to the UK, engaging international partners to help disrupt organised crime groups smuggling drugs through the UK's borders, and ensuring the retrieval of the proceeds and assets from the crimes these groups commit.

2.4 Policy Evaluations

2.4.1 Evaluation of the 2010 drug strategy

The UK government published *An evaluation of the government's drug strategy 2010* (Her Majesty's Government, 2017c) in July 2017 alongside the *2017 Drug Strategy*, which the evaluation informed. The evaluation was conducted by the Home Office in collaboration with other government departments and agencies, and focused on activities in England relevant to the aims of the strategy and for which there was at least some central government funding. Due to limitations of available data and evidence the analysis did not evaluate the strategy as a whole or attempt to produce a single value for money estimate, but instead looked at five activity groups: early interventions; media and information approaches; enforcement and enforcement-related activity; treatment; and non-treatment rehabilitative activity.

In relation to the aim of reducing illicit and other harmful drug use, the evaluation noted that while last year use of any drug remained stable over the period of the strategy among young adults (aged 16 to 24), use among schoolchildren (aged 11 to 15) dropped. The number of problem opioid and/or crack users estimated in 2011/12 (the most recent estimates available at the time of publication) was slightly lower than in 2009/10. Progress was found to have been made with regard to the second main aim of increasing the numbers recovering from

dependence, with successful completion rates having improved for both opioid and non-opioid drug treatment patients.

The evaluation of early interventions (for reducing demand) found that such interventions are effective at reducing risk factors and most likely to succeed when targeted at multiple risk behaviours. Expenditure on early interventions was estimated to have dropped over the course of the strategy. Recent government media and information activity targeted at reducing demand, such as FRANK and Rise Above (see section 3.3.2), was found to be evidence-based. Data suggests that the reach of these activities has risen, but there is insufficient evidence to determine whether they have been effective in changing behaviour, or to assess value for money.

Measuring the impact of enforcement and enforcement-related activity (aimed at restricting supply) is hampered by the lack of a comparator to the impact of no enforcement activity. The evaluation stated that enforcement may reduce use by raising prices, and that unintended consequences such as drug-related violence are possible as a result of drugs being illegal. It was also not possible to estimate value for money for this activity group.

Treatment (aimed at building recovery and reducing demand) was found to be well-evidenced and provided value for money, with the best available estimates suggesting that for every £1 spent on structured drug treatment, £2.50 was saved to society. Although there is good evidence for non-treatment rehabilitative initiatives in building recovery, and positive indications that specific interventions may be improving drug users' outcomes, there is insufficient evidence to estimate value for money for these types of activities.

2.4.2 Advisory Council on the Misuse of Drugs report on commissioning impact on drug treatment

In September 2017, the Advisory Council on the Misuse of Drugs made recommendations to help deliver the *2017 Drug Strategy* aspiration to have effectively funded and commissioned services, targeted at helping people fully recover from dependence (Advisory Council on the Misuse of Drugs, 2017). Recommendations include:

- national and local government protecting current levels of investment
- greater transparency from national government in financial reporting of local drug misuse treatment services
- national government carrying out a review into outcome measures and indicators for drug misuse treatment
- national bodies developing cost and staffing level quality standards
- the new Drug Strategy Implementation Board commissioning a national review of the drug misuse treatment workforce, compatible to benchmark against comparable EU countries
- strengthening links between local health systems and drug misuse treatment, in particular clinical commissioning group planning and commissioning
- recommissioning of treatment services to be undertaken in five- to ten-year cycles
- establishing mechanisms to avoid LAs having to re-procure systems which meet performance and quality indicators before contracts end

- the Drug Strategy Implementation Board addressing drug misuse research infrastructure and capacity, ensuring research groups are joined up with government departments, bodies such as the Medical Research Council and the National Institute for Health Research, and other stakeholders

2.5 Drug-related public expenditure

2.5.1 Prevention, harm reduction and treatment

England

LAs in England received a ring-fenced public health grant of £3.4 billion for public health services in the 2016/17 financial year.[17] Funding for drug and alcohol treatment is not ring-fenced within the public health grant, and expenditure on services is determined by an assessment of the populations' needs by local health and wellbeing boards. LAs are required to report their annual forecasted and actual expenditure on each public health intervention making up the grant. The categories for reporting this data include adult drug, adult alcohol, and young people's drug and alcohol spend. It is estimated that the LA's expenditure in 2016/17 will be £408 million on treatment of drug misuse in adults, £183 million on alcohol misuse in adults, £56 million on services for children and young people, and £111 million on preventing and reducing harm from drug/alcohol misuse in adults (Department for Communities and Local Government, 2016a).

The public health grant for 2017/18 has been confirmed as £3.3 billion. As part of the *2017 Drug Strategy* it was announced that the public health grant ring-fence would continue until April 2019, and will maintain the condition for LAs to "have regard to the need to improve the take up of, and outcomes from, drug and alcohol services" (Her Majesty's Government, 2017a).

Scotland

For the 2017/18 financial year, ADPs were granted £53.8 million to fund their services (Scottish Government, 2016a). The Scottish government's programme *A Nation with Ambition: the Government's Programme for Scotland 2017-18* (Scottish Government, 2017b) set out an additional £20 million for alcohol and drug misuse services in financial year 2018/19, although funding is still subject to Parliamentary scrutiny.

Wales

The Welsh government invests almost £50 million annually to deliver the commitments within its substance misuse strategy and its associated delivery plan (Welsh Government, 2016). As well as the £17.1 million ring-fenced funding within the health board budget for substance misuse services, the Substance Misuse Action Fund budget for 2014/15 stood at £32 million. Over £22 million of this funding goes directly to the seven area planning boards in Wales, which supports a number of projects ranging from education and prevention to treatment services.

Northern Ireland

Expenditure on drug and alcohol services has remained broadly consistent in Northern Ireland: around £8 million per year is allocated to the implementation of the *NSD Phase 2, 2011-2016* (Department of Health Northern Ireland, 2011) and a further £8 million is allocated to statutory addiction services through the mental health budget.

17 See: https://www.gov.uk/government/publications/public-health-grants-to-local-authorities-2016-to-2017

2.5.2 Enforcement

One component of the evaluation of the *Drug Strategy 2010* was to estimate the cost of drug-related enforcement for the 2014/15 fiscal year. The report stated that an estimated £1.6 billion was spent on enforcement activities, with close to one-third of costs associated with police enforcement (including drug seizures). However, it should be noted that data collection for these estimates are complicated, as many necessary data sources for calculating this estimate are not frequently recorded, so the value should be treated with caution (Her Majesty's Government, 2017c).

2.6 New developments

2.6.1 United Kingdom 2017 Drug Strategy

In July 2017, the UK government published its *2017 Drug Strategy* (Her Majesty's Government, 2017a) (see section 2.2.1). Similar to the previous strategy, the new strategy aims to reduce drug use and increase the rates of recovery from dependence, but also has enhanced measures on prevalence and recovery. A prominent addition to the *2017 Drug Strategy* was the development of global action as a fourth strand of core aims. An evaluation of the 2010 drug strategy was published at the same time (see section 2.4.1).

Reducing demand

The UK government's plan to reduce demand continues to emphasise a whole-life approach. Actions aimed at early intervention include providing advice and support to midwives, school nurses, and LAs on commissioning services from conception to the age of five. The government will continue to expand and develop universal prevention resources, including the Alcohol and Drugs Education and Prevention Information Service (ADEPIS) and Rise Above (see section 3.3.2), and will promote the European Drug Prevention Quality Standards. Vulnerable groups identified for targeted interventions include young people in substance misuse treatment, those not in education, employment or training, older users, the homeless and sex workers.

Restricting supply

Actions to combat international trafficking in the restricting supply strand include increasing international co-operation through the NCA sharing intelligence and collaborating with overseas law enforcement agencies, as well as capacity-building in key countries. The government intends to implement new detection technology at ports to increase the effectiveness of border checks. Other actions within this strand include tackling the sale of drugs on the dark net, and other crime associated with the drugs trade such as bribery and corruption, money laundering and firearms. Interventions for drug using offenders include increasing the use of treatment as part of a community sentence and encouraging greater use of test on arrest. There is a focus on actions relating to prisons including steps aimed at reducing drug supply and use in prison, and an intention to reassess treatment pathways for prisoners (see section 2.3.3).

Building recovery

The building recovery strand of the strategy includes actions to support commissioning of services by broadening outcomes data as well as sharing guidance and best practice documents. Building on the NPS clinical guidelines produced by Project NEPTUNE (Novel Psychoactive Treatment: UK Network), a national online learning programme for frontline workers (NEPTUNE

II) was released in January 2018.[18] The importance of treatment services in reducing DRDs is stressed, and efforts will be made to reach out to those with an unmet treatment need. In recognition of the high prevalence of smoking among drug users, treatment services should work with stop smoking services and offer smoking cessation to their clients. The government emphasised its commitment to improving the co-ordination of mental health services with the police and drug treatment services, and stated that it will produce guidance to support local areas to do so.

The importance of peer support for recovery is strongly supported by the evidence, and this is acknowledged in the strategy. PHE will continue to develop its Mutual Aid Toolkit and will explore the potential of online mutual aid groups. Actions around employment include the introduction of a new Work and Health Programme which will provide intensive and tailored support to those with a drug dependency. To improve the situation regarding housing and homelessness, the government will consider innovative approaches such as the Housing First model. Recognising the effect that parental substance misuse can have on children, PHE will be releasing a toolkit to support local responses to this issue.

Global action

The global action strand of the strategy includes activities regarding NPS. The UK will share information from the UK Focal Point early warning system network with international partners and will collaborate with relevant organisations to ensure international controls on the most harmful substances are put in place. The UK will increase engagement with source countries and will share best practice such as Project NEPTUNE. The strategy includes a commitment to supporting international research, for example through the UK's participation in the European Research Area Network on Illicit Drugs (ERANID), and states that the government will support the comprehensive package outlined in the World Health Organization's 2014 consolidated guidelines on HIV prevention. The UK government stated that it will work with international partners to improve access to controlled medicines for the majority of the world's population who live in countries with low or non-existent access to these. With regard to human rights, the government intends to lobby international partners to widen access to treatment and implement proportionate criminal justice responses, opposing the use of the death penalty in all circumstances. The strategy notes that the government will hold the international agencies it funds to account for compliance with their human rights obligations.

2.6.2 Safer drug consumption facilities

In February 2017, Glasgow City Integration Joint Board (IJB) approved a draft business case from the Health and Social Care Partnership (HSCP) proposing the development of a co-located safer drug consumption facility and heroin assisted treatment service. In June 2017 Glasgow City IJB was updated on progress towards this development on the following work-streams: a proposed location; operational parameters and principles; and evaluation, legal and financial frameworks (Glasgow City Integration Joint Board, 2017). Following the June update, the group also wrote to the Lord Advocate to ask him to consider varying existing prosecution guidance to effectively permit the lawful operation of a safer consumption facility. In November 2017, the Lord Advocate announced that he was unable to provide support for the facility,[19] and that the legal status of the site was the responsibility of the Home Office. By the end of 2017, the HSCP did not have the necessary authority to proceed with their plans; however, they continue to develop their proposal and work with partners to ensure that they can move ahead should there be a change in the legal situation. Work continues on the development of the plans in relation

18 See: http://neptune-clinical-guidance.co.uk/e-learning/

19 See: http://www.bbc.co.uk/news/uk-scotland-glasgow-west-41941699

to the heroin assisted treatment service with a working group progressing the work-streams set out above.

2.6.3 Helping workless families

In April 2017 the DWP published *Improving lives: Helping workless families*, a policy paper which proposed a trial of the individual placement and support (IPS) approach advocated by the Dame Carol Black review, to support those dependent on drugs and/or alcohol to enter or continue work (Department for Work and Pensions, 2017a). The proposals included building a network of peer mentors and expanding the eligibility of the existing Access to Work grant funding, to include those on a treatment programme. PHE is leading on the IPS randomised controlled trial for people in drug and alcohol treatment, funded by the DWP and DHSC's Joint Work and Health Unit's Innovation Fund. PHE has confirmed the seven LAs that will be moving forward in the trial, which is expected to go live in April 2018 (Public Health England, 2017j).

The DWP also published a report in April 2017 detailing the views of benefit claimants and previous claimants with drug and alcohol misuse issues as well as those of stakeholders, which had been collated as part of the 2016 Dame Carol Black review (Department for Work and Pensions, 2017b). The key findings were that while work was viewed as a critical part of the client's journey, boosting self-esteem and helping to maintain recovery, it was essential that it be undertaken only at the right stage of recovery, and that the type of work should be appropriate. This could include voluntary, part time and/or flexible working. Entering into stressful working conditions too early in recovery was seen as a potential trigger for relapse. As such, the benefits system was seen as having an important role to play in supporting those in recovery.

2.6.4 Substance misuse in older adults in Wales

In February 2017, the Welsh Advisory Panel on Substance Misuse (APoSM) published a report on *Substance Misuse in an Ageing Population* (Advisory Panel on Substance Misuse, 2017). This report on older adults (defined as those aged 50 and over) drew upon academic evidence, public health data and the knowledge and experience of those who attended an expert evidence-gathering day.

The report concluded that substance misuse among older adults is a growing problem. Widespread use of illicit drugs has not been reported among older adults; however, there is a concern that illicit use may increase in the future, as the age of those receiving treatment has increased, due to the ageing cohort of heroin users (see section 1.5.1). The report suggested that prescription and over the counter drug consumption has a high potential for abuse, as over 80% of older adults in Wales report taking medication for extended periods of time (one year or more). Treatment is often not accessible to the older population, especially as there are few older-adult specialist treatment services, despite drug-related mortality rates being higher among this population. Overall, the report stated that the growing substance misuse problems experienced by older adults are not being fully addressed.

Recommendations made by the APoSM included: for services to be more accessible and welcoming; for other services supporting older adults to be aware of the potential for substance misuse by clients; for treatment services to account for changing patterns of use and to adapt appropriately; for new service provision approaches to be piloted and evaluated; and for relevant bodies to share and promote good practice. Research, analysis and modelling of the future health burden of substance misuse should be undertaken to enable services to plan more effectively. Sustaining tenancy for older tenants must be a priority, and should be proactively assessed by landlords. Older prisoners and those leaving prisons require continued attention.

2.6.5 Payment by results pilot evaluation

Starting in April 2012, eight local areas of England were selected to take part in a payment by results drug and alcohol recovery pilot. Under this programme, a proportion of payments made to treatment providers were linked to the attainment of specific outcomes by their clients, with the intent of testing and developing this approach to treatment funding. An evaluation of this pilot was published in October 2017 (see section 4.9.4).

3 Prevention

3.1 Introduction

Reducing drug misuse remains a key part of the UK government's *2017 Drug Strategy*, expanding on the previous strategy published in 2010. The strategy aims for "fewer people to use drugs in the first place" and, for those that do, "prevent escalation to more harmful use" (Her Majesty's Government, 2017a). It sets out methods to tackle the risk factors that make people vulnerable to substance misuse, which include investing in a range of evidence-based programmes that have a positive impact on young people and adults, giving them the confidence, resilience and risk management skills to resist drug use and recover from set-backs.

The role of prevention initiatives is also stressed in each of the drug strategies of the devolved administrations. Throughout the UK, emphasis is put on establishing a whole-life approach to prevention covering early years, family support, drug education and targeted specialist support. Drug strategies favour a broad approach to prevention not aimed specifically at drugs, but targeted instead at strengthening general resilience factors associated with reducing the desire to explore risky behaviours including drug use. In addition to universal prevention initiatives aimed at all young people, there are targeted actions for those most at risk of using drugs, or those who have already started using drugs. For a further description of the prevention policies in each of the countries in the UK, in particular the early years prevention and intervention agendas, see section 2.3.1.

Specialist substance misuse treatment for young people aims to reduce harm, stop use from escalating and prevent clients becoming drug or alcohol-dependent adults; as such it is recognised as a form of prevention in the UK. The majority of young people presenting to substance misuse services in 2016/17 cited cannabis (77%) or alcohol (15%) as their primary problematic substance, as has been the trend since 2005/06 (Public Health England, 2017o). Over the past decade there has been a decreasing number of young people presenting for treatment citing opioids as their primary substance, from 881 in 2005/06 to 94 in 2016/17. Following five years of decreasing presentations for powder cocaine, the number of young people citing this substance has remained stable for the past four years (see section 3.5.1).

3.2 The evolution of prevention approaches

Since the late 1990s many drug prevention programmes have been evaluated in the UK, showing that the impact of drug education alone is unlikely to prevent young people from using drugs. It has been demonstrated that 'scare' approaches are likely to be ineffective, if not counterproductive. However, if drug education is delivered as part of a more holistic approach it can contribute towards a decrease of harmful behaviours, increasing safety for young people, their families and communities. Therefore, in recent years the focus of prevention policy has shifted away from interventions aimed specifically at drugs, to strengthening general resilience factors associated with the aim of reducing the desire to explore risky behaviours including drug use (Faggiano, Minozzi, Versino, & Buscemi, 2014; James, 2011; UK Drug Policy Commission, 2012).

A stronger emphasis has also been put on the importance of parent/carers and family influence on children's substance misuse and associated behaviours, and how early life interventions, which should include prenatal family support, can reduce risk factors and strengthen the associated protective factors. Such interventions can include parenting skills education, support

to families from pregnancy such as the Family Nurse Partnership (see section 3.5.2), and parent and family skills training such as the Strengthening Families Programme (UK Focal Point, 2014).

There has also been a shift in how drug education and prevention programmes aimed at young people have been delivered. Earlier prevention strategies focused on approaches that provided information on the consequences of engaging in risky behaviour, usually targeting individual risky behaviour such as smoking, alcohol consumption, risky sexual behaviour, and drug use. These approaches are based on the hypothesis that young people do not have a clear understanding of the potential consequences involved in participating in risky behaviour, and providing them with this information would make such behaviour less appealing. Often the information was provided using a passive form of learning, with very little or no participation from the targeted audience.

More recent education and prevention programmes take into account the concept that young people's behaviour is affected by the perceived behaviour of their peers, in particular their tendency to overestimate the prevalence of risky behaviours among their peers. Therefore, providing them with information about the real prevalence of such risky behaviours might reduce their participation in such actions (such as the 'social norm' approach (Chowdry, Kelly, & Rasul, 2013)). Some of these programmes tend to focus on relationships between individual behaviours and a range of social and environmental influences they are subject to, and the inter-relationship between individual behaviours as 'lifestyles'. Such programmes put an emphasis on the need to communicate effectively with young people through a range of networks (such as web-based activity) and through the media, as well as through traditional school health education. These approaches have increasingly used social marketing methodologies, which advocate an integrated 'whole person' approach, to disseminate their message and to support behaviour change in young people.

The report by the Advisory Council on the Misuse of Drugs, *Prevention of drug and alcohol dependence* (Advisory Council on the Misuse of Drugs, 2015), highlighted a range of effective and ineffective practices in preventing substance misuse. In February 2017 the National Institute for Health and Care Excellence (NICE) published *Drug misuse prevention: targeted interventions (NG64)* (National Institute for Health and Care Excellence, 2017), providing guidance on assessing someone's vulnerability to drug misuse, improving the information and skills available to those assessed vulnerable and delivering effective prevention services (see section 3.7.1).

3.3 Universal prevention

There are a number of universal prevention programmes in place in each of the four countries of the UK, in line with each country's drug strategy priorities. While individual programmes are not implemented in entirety across the UK, the focus on building young people's resilience is broadly similar in each country.

3.3.1 United Kingdom

Good Behaviour Game

The Good Behaviour Game is a classroom-based approach that has been trialled in other countries around the world. A trial is ongoing in UK primary schools, funded by the Education Endowment Fund and led by Mentor UK. The programme is an approach to classroom management and aims to develop life skills in young people, helping to build resilience and confidence in dealing with challenges. Evaluations in other countries have shown long-term

benefits such as a reduction of risk-taking behaviour, including substance abuse, later in life. An evaluation report for the UK programme is due to be published in summer 2018.

Unplugged

Unplugged is an intervention aimed at 12-14 year-olds and is delivered through a series of 12 one-hour modules in schools. The programme has been trialled in a number of European countries and has been shown to be effective in preventing and reducing alcohol misuse and smoking. It aims to give young people the skills they need to resist influences from peers, and provides them with information regarding the negative health consequences of drug use.

3.3.2 England

Universal drug education is included in the national curriculum in England, where it is a statutory part of the science curriculum for schools. Pupils are required to be taught "the effects of 'recreational' drugs (including substance misuse) on behaviour, health and life processes". Drug education can be expanded through the non-statutory personal, social and health education (PSHE) programme; however, there is no standardised approach for doing so. Guidelines state that teaching should draw on good practice (Department for Education, 2014). Evidence suggests that well-delivered PSHE can have a positive effect on young people, and that interventions that help build confidence and resilience can prevent drug use (Home Office, 2016b). The *Children and Social Work Act 2017*, enacted in April 2017, makes provision of relationships and sex education compulsory in all schools in England (Her Majesty's Government, 2017b). The act also provides the Education Secretary with the capacity to make PSHE mandatory in all schools, following appropriate consultation.

Alcohol and drug prevention briefing papers

As part of a series of briefing papers for teachers and practitioners, Mentor-ADEPIS (Alcohol and Drug Education and Prevention Information Service) published a document in 2016 that looked at how building resilience and preventing children and young people's mental ill health can prevent substance abuse (Mentor-ADEPIS, 2016). The paper provided teachers, educators and the wider school workforce with practical guidelines on how to prevent children and young people from developing mental health problems as a result of alcohol and drug misuse. A follow-up paper was published in March 2017. *School-based alcohol and drug education and prevention – what works?* (Mentor-ADEPIS, 2017) aims to enable educators to make a more informed decision when selecting an alcohol and drug education programme, ensuring that young people receive the most appropriate education to help build their resilience to risks (see section 3.7.7).

In 2016 the Association for Young People's Health (AYPH), in conjunction with Public Health England (PHE), published *A public health approach to promoting young people's resilience*, which focuses on building resilience in young people (Association for Young People's Health, 2016). This document is aimed at policy-makers, commissioners and service planners and providers, and builds on previous work such as the PHE framework for young people's health, and resources such as Rise Above (see below).

Sources of support and information about drugs

There are several universal prevention communication programmes in England. Talk to FRANK,[20] a campaign from PHE, provides information about drugs to young people (aged under 16) and their families. Advice can be accessed through channels such as a 24-hour helpline operated

20 See: http://www.talktofrank.com/

by trained advisors, the FRANK website, SMS, email and a live online chat service. There have been increases in the number of website visits and emails to FRANK in recent years (2.2 million in 2009/10 to 6.0 million in 2016/17).

Rise Above[21] is another PHE prevention communication programme. It is an interactive resource where young people can find material aimed at encouraging them to build resilience, feel empowered and talk about important issues in their life, including drugs, alcohol and smoking. Rather than providing information only, a range of situational tools and skills-based resources are available on the website. From its launch in 2015 to April 2017, Rise Above has received over 490,000 visits to the website, 1.09 million views of Buzzfeed posts, and 6.4 million video views of Rise Above content across vloggers and the Rise Above channel on YouTube. There have also been 52,429 unique visits to the MTV Rise Above Wall, a resource that allows young people to anonymously ask questions about smoking drinking and drugs, and for the response from a trained advisor to be shared on the wall page.

In addition, PHE has developed its role in supporting local areas, by sharing evidence to support commissioning and the delivery of effective public health prevention activities, and launching toolkits to support local areas' responses to specific issues around new psychoactive substances (NPS) and other drug groups.

3.3.3 Scotland

In Scotland, education has developed to encapsulate broader life learning for children and young people through the Curriculum for Excellence,[22] where traditional education is integrated with wider life learning for three to 18-year-olds. In the Curriculum for Excellence, learning in health and wellbeing is designed to promote confidence, independent thinking and positive attitudes. This helps to enable children and young people become resilient to risk-taking behaviours and understand the wider impacts of staying safe and making positive choices.

In December 2016, the Scottish government produced a literature review examining best practice in school-based drug education and prevention (Scottish Government, 2016f). The report argued that drug prevention is better provided through holistic strategies that promote healthy development and wellbeing, with targeted drug-specific interventions provided for those most at risk of harm or already misusing drugs.

Know the Score

Know the Score[23] provides information and advice about drugs to young people, their families and professionals. It is supported by the Scottish government and provides a 24-hour online information service, and a telephone helpline from 8am to 11pm, seven days a week.

Choices for Life

The Scottish government funds the Choices for Life[24] school-based substance misuse education programme, delivered in partnership with Young Scot and Police Scotland. This programme provides education on drugs, alcohol and tobacco through a website for young people and their parents, teachers and carers. It also provides a series of community events to help engage young people directly and provide credible information to help them make healthy choices.

21 See: https://riseabove.org.uk

22 See: https://education.gov.scot/scottish-education-system/policy-for-scottish-education/policy-drivers/cfe-(building-from-the-statement-appendix-incl-btc1-5)/What%20is%20Curriculum%20for%20Excellence?

23 See: http://knowthescore.info/

24 See: http://young.scot/choices-for-life/

The Choices for Life website hosts a series of interactive short films to educate teenagers on a wide range of topics including the dangers of NPS, peer pressure, substance misuse and drug driving.

In 2015/16 Choices for Life aligned itself with Rock Challenge, a performing arts initiative which delivers positive healthy lifestyle messages to young people. Rock Challenge raises awareness of social issues affecting young people including smoking, drugs, alcohol and anti-social behaviour, and encourages them to make informed lifestyle choices. Police Scotland allocated a support officer to the participating schools and made funding available to help with their projects.

In light of the findings of the literature review *'What works' in drugs education and prevention?* (Scottish Government, 2016f), the Scottish government is currently reviewing the education and prevention activities that it supports directly, to ensure that these are in line with the evidence base. A review of the Choices for Life programme was commissioned in May 2017 and is being carried out by Mentor UK.

3.3.4 Wales

In line with the goals laid out by *Working Together to Reduce Harm: The Substance Misuse Strategy for Wales 2008-18* (Welsh Assembly Government, 2008a), the All Wales School Liaison Core Programme has been developed to deliver drugs education in primary and secondary schools.[25] The *Steroids and Image Enhancing Drugs Educational Toolkit for Young People (11-16 years)* was developed and issued in 2014 for use by all schools and youth groups across Wales (Public Health Wales, 2014b).

Welsh Network of Healthy School Schemes

The Welsh Network of Healthy School Schemes (WNHSS)[26] is an initiative to ensure schools adopt a holistic approach to health and wellbeing, including a focus on substance use (both licit and illicit). Each local authority (LA) employs healthy schools practitioners to support schools to implement and embed health topic areas. Once schools are confident that they are providing an effective health promoting setting to improve the health and wellbeing of pupils, they can apply for the National Quality Award (NQA). This award externally assesses the school on its approach to the seven key topic areas of: food and fitness; mental and emotional health and wellbeing; personal development and relationships; substance use and misuse; environment; safety; and hygiene. In September 2017, 127 schools across Wales had achieved the NQA, an increase from 87 in August 2015. A further 442 are working towards being assessed (personal communication – Public Health Wales).

Healthy and sustainable further education and higher education settings

The Healthy Colleges and Healthy Universities framework[27] was launched in Wales in 2015 as an extension of the WNHSS into Higher Education in Further Education settings. One of the six health topics detailed in the framework is substance use and misuse. The framework sets out criteria for various aspects of college and university life, covering governance, leadership and management; facilities, environment and service provision; community and communication; and academic, personal, social and professional development. It aims to create a healthy and

25 The All Wales School Liaison Core Programme (AWSLCP) is jointly funded by the Welsh Government and the four Welsh police forces and targets pupils aged between five and 16. See: https://www.schoolbeat.org/en/parents/know-the-programme/national-events/what-is-the-all-wales-school-liaison-core-programme/

26 See: http://www.wales.nhs.uk/sitesplus/888/page/82249

27 See: http://www.wales.nhs.uk/sitesplus/888/document/270938

sustainable further education environment for both staff and students and provides guidance on how this may be achieved.

DAN 24/7

Dan 24/7[28] is a bilingual (Welsh and English) 24-hour information and telephone helpline service, hosted by the Betsi Cadwaladr University Health Board with funding provided by the Welsh government. In 2015/16 there were 4,339 calls to DAN 24/7, an 8.7% increase on 2014/15. Traffic to the website increased by 12% during the same timeframe. DAN 24/7 often runs targeted campaigns; it has been updated to reflect current issues such as NPS, and ran a recent campaign to raise awareness of hepatitis C in Wales. The service has also increased its presence on social media platforms in recent years. The helpline is aimed at assisting individuals, their families, carers, and support workers within the drug and alcohol field to access appropriate local and regional services.

3.3.5 Northern Ireland

The Northern Ireland school curriculum places a specific focus on the development of relevant life skills among pupils (Department of Education, 2007). In particular, pupils are provided with opportunities to develop strategies and skills for keeping themselves healthy and safe through Personal Development and Mutual Understanding[29] in primary schools. Learning for Life and Work[30] provides post-primary school pupils with opportunities to investigate the effects on the body of licit and illicit substances and the risks and consequences of their misuse.

During the 2014/15 financial year the Council for Curriculum, Examinations and Assessment (CCEA) updated the CCEA/Department of Education guidance on drugs and alcohol. The new guidance was published on the CCEA website in August 2015.[31] In Northern Ireland, the Public Health Agency (PHA) develops public information campaigns for various target groups and settings. In addition, Northern Ireland buys into the telephone helpline element of the FRANK campaign.

A community support and local awareness raising service, called Connections, was put in place in July 2015 to raise awareness of the harm that alcohol and drug misuse can cause, work with local communities to address their priorities, and raise awareness of local services.

Thingy App

The Police Service of Northern Ireland, Big Lottery Fund, Youth Justice Agency and Family Support Northern Ireland have funded an app, designed by young people, called Thingy App. Thingy App offers young people health advice, including advice on drugs and alcohol, and signposts individuals to agencies where they can receive further help and information.

3.4 Environmental prevention

Environmental prevention strategies aim to alter the immediate cultural, social, physical and economical environments in which people make their choices about drug use.

28 See: http://www.dan247.org.uk

29 See: http://ccea.org.uk/curriculum/key_stage_1_2/areas_learning/personal_development_mutual_understanding

30 See: http://ccea.org.uk/curriculum/key_stage_4/areas_learning/learning_life_and_work

31 See: http://ccea.org.uk/curriculum/drugs_guidance

3.4.1 Blanket ban on psychoactive substances

The *Psychoactive Substances Act 2016* (Her Majesty's Government, 2016c) places a ban on all psychoactive substances (with some exemptions) in the UK. This legislation prohibits the production, distribution, sale and supply of substances capable of producing a psychoactive effect, and the possession of these substances within custodial settings. Exempted substances are: those substances already controlled under the *Misuse of Drugs Act 1971*; medicinal products listed under *The Human Medicines Regulations 2012*; alcohol; tobacco and nicotine products; caffeine; and food and drink. The main aim of the *Psychoactive Substances Act 2016* is to halt the sale and supply of psychoactive substances through retail premises (such as headshops) and online retailers based in the UK (see section 8.2.3).

3.4.2 Drinking and drug driving legislation

England and Wales

In March 2015 levels for the maximum blood concentration allowed for a selection of illicit drugs and medications for drivers were introduced in England and Wales under *The Drug Driving (Specified Limits) (England and Wales) Regulations 2014* (Her Majesty's Government, 2014a). Limits are specified for eight illicit drugs including cannabis, heroin and cocaine,[32] and nine medicines which may be abused (the limits for these compounds are higher to reflect their medical use).[33]

Scotland

In Scotland it is currently an offence to drive while 'impaired' by drugs. However, in April 2017 the Scottish government announced that new drug driving limits, similar to those which are currently in use in England and Wales, will be introduced in 2019.[34] It is hoped that this will eliminate the need for enforcement officers to gather evidence that a driver is impaired, and will enable them to prosecute on the basis of the specified limits instead. Drug driving will carry the same maximum penalties as drink driving: a minimum 12-month driving ban, up to six months in prison and a fine of up to £5,000.

Northern Ireland

Under the *Road Traffic (Amendment) Act (Northern Ireland) 2016* (Her Majesty's Government, 2016d), the legal alcohol limit for drivers has been lowered from 80 mg per 100 ml of blood to 50 mg per 100 ml. The limit for learner and professional drivers is lower, at 20 mg per 100 ml. The recent drug driving laws introduced in England and Wales do not extend to Northern Ireland; however, individuals may still be arrested if they are unfit to drive.

3.4.3 Alcohol minimum unit pricing

In 2009 the Sheffield Alcohol Research Group (SARG) at the University of Sheffield developed the Sheffield Alcohol Policy Model (SAPM) to evaluate the possible impact of alcohol policies, including different levels of minimum unit pricing (MUP) on the English population (Purshouse et

32 Illicit drug limits in the legislation: benzoylecgonine, 50 µg/L; cocaine, 10 µg/L; delta-9-tetrahydrocannabinol (cannabis), 2 µg/L; ketamine, 20 µg/L; LSD, 1 µg/L; methamphetamine, 10 µg/L; MDMA, 10 µg/L; and 6-monoacetylmorphine (heroin), 5 µg/L

33 Medicines and limits in the legislation: amphetamine, 250 µg/L; clonazepam, 50µg/L; diazepam, 550µg/L; flunitrazepam, 300µg/L; lorazepam, 100µg/L; methadone, 500µg/L; morphine, 80µg/L; oxazepam, 300µg/L; and temazepam, 1,000µg/L

34 See: https://news.gov.scot/news/new-curbs-against-drug-driving

al., 2009). Since then, the SAPM has been adapted to a range of settings including Scotland, Wales and Northern Ireland (Angus, Scafato, et al., 2014; Hill-McManus et al., 2012; Meng, Brennan, & Meier, 2012).

The UK Supreme Court confirmed in November 2017 that legislation passed by the Scottish government in 2012 was lawful, following successive legal challenges. MUP for alcohol is due to be implemented in Scotland from May 2018.

Legislation proposing to introduce MUP for alcohol in Wales, and to enable ministers to set minimum prices, was introduced to the Welsh Assembly on 23 October 2017, and MUP legislation is also being considered by the administration in Northern Ireland.

Scotland

In 2012 SARG reported to the Scottish government on the possible effects of introducing MUP in Scotland, modelling the potential impacts of minimum unit prices from 25-70p, with or without a concomitant ban on off-trade discounting (Meng et al., 2012). Introduction of MUP was predicted to decrease consumption, hospital admissions, deaths, alcohol-related crime and workplace absenteeism. Higher levels of MUP were predicted to have the greatest effect, with a discount ban increasing these benefits.

The *Alcohol (Minimum Pricing) (Scotland) Act 2012* was passed and received Royal Assent in 2012 (Scottish Parliament, 2012). The Scotch Whisky Association (SWA) unsuccessfully challenged the legality of MUP in the Court of Session in 2013 and, in conjunction with the European Spirits Organisation and the Comité Européen des Entreprises Vins, appealed to the European Court of Justice. Following a ruling from the European court in 2015 that the decision to implement MUP was for the national courts to make, the Scottish Court of Session ruled against the SWA's appeal in 2016. The SWA appealed this decision in the UK Supreme Court; however, the Supreme Court ruled that the legislation was lawful in November 2017 (UK Supreme Court, 2017). Implementation of the act is expected to occur in May 2018.

England

PHE published an evidence review on the cost of alcohol-related harms and the effectiveness of alcohol control policies in December 2016 (Public Health England, 2016d). The review postulated that implementing MUP would be a cost effective way to improve the health of the heaviest drinkers, and therefore those who are experiencing the most harm, while having a negligible impact on moderate drinkers. The review also stated that implementation of MUP in isolation was not as effective as when combined with an increase in taxation.

The introduction of MUP in England remains under review following the ruling of the UK Supreme Court, pending the impact of its implementation in Scotland.[35]

Wales

SARG was commissioned by the Welsh government to adapt the SAPM to the Welsh population and the results were published in 2014 (Meng, Sadler, Gell, Holmes, & Brennan, 2014). The analysis modelled the possible impact of MUP policies ranging from 35-70p per unit of alcohol over a 20 year period, and estimated the impact of a ban on below-cost selling. The report concluded that MUP would be effective in reducing alcohol consumption, alcohol-related harms and the costs associated with them in Wales. The Welsh study did not look at the estimated impact of a ban on price-based promotions in the off-licensed trade.

35 See: http://www.parliament.uk/business/publications/written-questions-answers-statements/written-question/Lords/2017-11-28/HL3657/

A consultation for the draft *Public Health (Minimum Price for Alcohol) (Wales) Bill* (Welsh Government, 2015a) was launched in July 2015 and legislation was proposed before the Welsh Assembly on 23 October 2017. The bill proposes:

- a formula for calculating the MUP using the alcohol by volume measure
- powers for Welsh ministers to make subordinate legislation to set MUP for alcohol sold or supplied in Wales
- to establish an LA-led enforcement programme with powers of entry, powers to bring prosecutions for offences and to issue fixed penalty notices

Northern Ireland

In 2013, the then Department of Health, Social Services and Public Safety (now the Department of Health (DoH)) and the Department for Social Development commissioned SARG to adapt the SAPM to Northern Ireland (Angus, Meng, Ally, Holmes, & Brennan, 2014). The study modelled the potential impact of a range of MUP policies from 35-75p per unit of alcohol over a 20 year period, and separately modelled the impact of bans on below-cost selling[36] and on price-based promotions in the off-licensed trade. The authors concluded that MUP would be effective in reducing alcohol consumption, alcohol-related harms and the costs associated with them. It was estimated that the ban on below-cost selling would have almost no impact on the population's alcohol spending or consumption, or on alcohol-related harms. However, a ban on price-based promotions in the off-licensed trade, either alone or in conjunction with a MUP policy, would be effective in reducing alcohol consumption, related harms and associated costs.

Following on from the evidence provided by this study, in December 2014 the Northern Ireland Health Minister announced the intention to develop a policy to introduce MUP in Northern Ireland. A consultation paper is under development, and the issue remains as a policy option for consideration.

3.4.4 Tobacco control

United Kingdom

Standardised packaging of tobacco

The Standardised Packaging of Tobacco Products Regulations 2015 (Her Majesty's Government, 2015d) came into effect in May 2016, following the dismissal of a legal challenge to the legislation brought by tobacco companies. The regulations include a ban on packs of ten cigarettes and a ruling that all tobacco packaging must be uniformly olive green and display large health warnings; this includes both packets of cigarettes and hand rolling tobacco. Tobacco companies complied with the new regulations within the one year timeframe, ending 21 May 2017.

E-cigarettes

Since May 2016, all e-cigarettes and e-liquids sold in the UK must either meet the provisions of the Tobacco Products Directive (TPD) (2014/40/EU) (Official Journal of the European Union, 2014) or be licensed as a medicine or medicinal device by the Medicines and Healthcare products Regulatory Agency. Though implemented since May 2016, retailers were given until May 2017 to sell their stock of products that did not comply with the labelling and product composition requirements of the TPD. In areas outside of the harmonised rules set out in the

36 Below-cost selling refers to a ban on selling any alcoholic drinks for below the cost of duty plus the VAT payable on the duty

TPD, the countries of the UK may, within the scope of their devolved powers, make their own policy on e-cigarettes.

England

In August 2015, PHE published an expert independent review of the latest evidence on e-cigarettes (Public Health England, 2015b). The authors found that: there was no evidence at that time that e-cigarettes act as a route into smoking for children and young people; e-cigarettes have become the most popular stop smoking aid in England and can help smokers to quit; and while not completely risk free, e-cigarettes are around 95% less harmful for users than cigarettes.

In October 2015, *The Smoke-free (Private Vehicles) Regulations 2015* (Her Majesty's Government, 2015c) made it illegal to smoke in a private vehicle with someone aged under 18 present. In the same month, *The Proxy Purchasing of Tobacco, Nicotine Products etc. (Fixed Penalty Notice) (England) Regulations 2015* (Her Majesty's Government, 2015b) came into force, prohibiting the sale of e-cigarettes to under-18s and the purchase of e-cigarettes by adults on their behalf.

In July 2017, the then Department of Health (DH) published *Towards a smoke-free generation, a tobacco control plan for England* (Department of Health, 2017b). Building on progress since the last plan was enacted in 2011, it sets out national objectives to: reduce the number of 15-year-olds who regularly smoke, from eight per cent to three per cent or less; reduce smoking among adults in England from 15.5% to 12% or less; reduce the inequality gap in smoking prevalence between those in routine and manual occupations and the general population; and reduce the prevalence of smoking in pregnancy from 10.5% to six per cent or less. The government aims to achieve these objectives by the end of 2022, and ultimately to progress to a smoke-free generation.[37]

The plan provides a range of actions targeted on four main themes; prevention first; supporting smokers to quit; eliminating variations in smoking rates; and effective enforcement. Actions supporting the prevention first theme include ensuring "the effective operation of legislation such as proxy purchasing and standardised packaging designed to reduce the uptake of smoking by young people" and a commitment to "review the type and level of sanctions for tobacco retailers who repeatedly break laws designed to protect young people." Additionally, there is a commitment to continue to develop the tobacco control evidence base by funding further research, and PHE will support local areas looking to implement smoke-free places policies.

Smoke-free prisons were trialled in four early adopter sites in England, which was extended to seven further establishments in January 2017, with a view to the entire prison estate becoming smoke-free by September 2018. E-cigarettes and nicotine replacement therapies (NRT) are available for prisoners to purchase, and access to stop smoking support is increasing throughout the estate (see section 5.9.7)

Scotland

In February 2017, the *Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016* (Scottish Parliament, 2016a) came into force. Alongside the Scottish government's latest tobacco control strategy, *Creating a Tobacco-Free Generation: A Tobacco Control Strategy for Scotland* (Scottish Government, 2013a), this act supports the Scottish government's objective to support longer, healthier lives and to tackle the significant inequalities in Scottish society. It will do this in the main by restricting the accessibility of nicotine vapour products to young people; reducing their visibility and appeal to young people and non-smokers; reinforcing the age restriction

37 Referring to when national smoking prevalence is at five per cent or below

on tobacco products to further protect young people; and introducing statutory smoke-free perimeters around buildings on NHS hospital sites.

The *Smoking Prohibition (Children in Motor Vehicles) (Scotland) Act 2016* (Scottish Parliament, 2016b) came into force on 5 December 2016. This legislation makes it an offence for an adult to smoke in a private motor vehicle when there is a child under the age of 18 in the vehicle, and the vehicle is in a public place.

The *Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016* (Scottish Parliament, 2016a) came into force on 1 April 2017, banning e-cigarette sales to under-18s in Scotland.

In March 2016 the Cabinet Secretary for Justice in Scotland accepted the recommendation that all Scottish prisons should be smoke-free within a timescale of up to five years. The current position is that prisoners are only permitted to smoke in their own cells and during outdoor recreation. Staff, visitors, and contractors are not permitted to smoke anywhere on SPS property. In response to research into levels of second-hand smoke in Scottish prisons, in July 2017 SPS announced its intention to bring forward the implementation of smoke-free prisons to November 2018.[38] SPS will be working closely with NHS health boards and Scottish government as well as other partner agencies to develop comprehensive plans in preparation for the change. A decision has still to be made on whether e-cigarettes should be introduced to prisons in Scotland as part of moves towards smoke-free prisons.

Wales

The *Public Health (Wales) Bill* was introduced by the Welsh government in November 2016, passed by the National Assembly in May 2017, and the *Public Health (Wales) Act 2017* came into force on 3 July 2017 (National Assembly for Wales, 2017). The act introduced a series of measures in priority areas of public health policy, including policies on tobacco and nicotine products, and:

- restricts the use of e-cigarettes, banning them in enclosed public spaces and workplaces
- requires sellers to join a register for retailers of tobacco and e-cigarettes
- makes it an offence to 'hand over' tobacco and e-cigarette products to people under the age of 18

In September 2017, the Welsh government published the *Tobacco Control Delivery Plan for Wales 2017-2020* (Welsh Government, 2017). The plan guides activity to monitor delivery of and progress towards the goals set in the *Tobacco Control Action Plan for Wales* (Welsh Government, 2012), including the overarching target to reduce smoking prevalence for adults to 16%, and for 15-16 year-olds to five per cent, by 2020.

The plan is divided into four main action areas: promoting leadership in tobacco control; reducing the uptake of smoking; reducing smoking prevalence levels; and reducing exposure to second-hand smoke. The overall goal set out is for a smoke-free future generation where harm from tobacco is eradicated.

Following a phased implementation period, all prisons in Wales have been smoke-free since May 2016. E–cigarettes and NRT are available to buy in prisons, and NRT can be obtained as part of a stop smoking service intervention through prison health services.

38 See: http://www.sps.gov.uk/Corporate/News/Creating_a_Smoke_Free_Prison_Environment.aspx

Northern Ireland

The *Tobacco Retailers Act (Northern Ireland) 2014* (Her Majesty's Government, 2014c) strengthened existing age of sale legislation by requiring all tobacco retailers in Northern Ireland to register centrally from April 2016. The act also introduced banning orders for retailers; fixed penalties for a number of tobacco-control offences; and a new offence of proxy purchasing (buying tobacco on behalf of a minor).

The *Health (Miscellaneous Provisions) Act (Northern Ireland) 2016* (Her Majesty's Government, 2016b), passed in May 2016, allows a ban on smoking in cars where children are present, and makes provision in relation to age of sale restrictions for e-cigarettes. The DoH held a consultation on the regulations, which closed on 3 March 2017. The results have not yet been published.

3.5 Selective prevention in at-risk groups and settings

There are a series of prevention activities underway in the UK that focus on particular at-risk groups including young people with multiple vulnerabilities, young mothers and 'troubled families'.

3.5.1 Young people

Substance misuse services for young people in England

Specialist substance misuse treatment for young people is recognised as a form of prevention in the UK, as it aims to stop drug and alcohol use escalating, reduce harm to young people or others, and prevent them becoming drug or alcohol-dependent adults.

The *Young People's Statistics from the National Drug Treatment Monitoring System (NDTMS)* annual report showed that in 2016/17 16,436 young people (under 18 years) accessed specialist substance misuse services in England, down from 17,077 in 2015/16 (a 3.9% decrease) (Public Health England, 2017o). The majority presented with cannabis (77%) or alcohol (15%) as their primary problematic substance, followed by ecstasy (2.1%, n=340), cocaine (1.5% per cent, n=254) and NPS (1.3% per cent, n=213).

Alcohol was the most common adjunctive substance reported by young people in treatment in England in 2016/17. Of the 12,712 treatment clients aged under 18 years, 5,593 (44%) reported alcohol as an adjunctive substance. Not including nicotine, the next most common adjunctive substances reported were cannabis (n=1,737), ecstasy (n=1,475) and cocaine (n=1,219).

Those waiting to commence their first treatment intervention waited an average of two days to start treatment, and 98% waited less than three weeks from the point of referral to their first appointment. In 2016/17 10,834 individuals under the age of 18 exited treatment, 82% of whom did so in a planned way and no longer required specialist treatment.

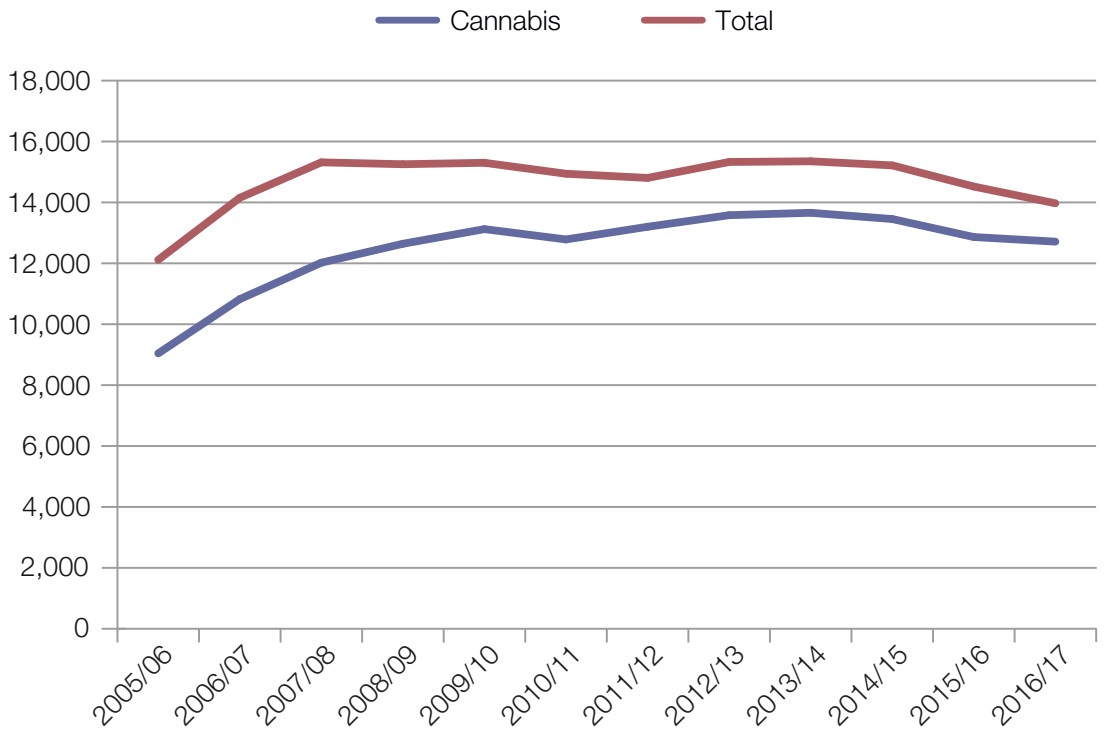
Young people presenting to specialist substance misuse services frequently have multiple vulnerability factors, such as being a looked after child, being involved in child sex exploitation, or having a history of self-harm or offending behaviour. The young people's statistics from NDTMS identify 17 of these vulnerability factors.[39] Of the 11,753 new presentations in 2016/17, 80% had two or more vulnerability factors (Public Health England, 2017o).

39 See: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/664945/Young-people-statistics-report-from-the-national-drug-treatment-monitoring-system-2016-2017.pdf

Trends in young people in treatment

Although there has been a decline in self-reported use of cannabis among schoolchildren in population surveys (see section 1.3.1), the number of young people in treatment for primary cannabis use increased between 2006/07 (n=10,824) and 2013/14 (n=13,659). One possible reason for diverging trends could be increasing problems experienced as a result of changes in the type and potency of cannabis available (see section 1.3.2 and section 9.4.1). There has been a reduction in the number of young clients in treatment for primary cannabis use over the past three years, and in 2016/17 the number was 12,712 (91% of all young people in treatment for drug use) (see Figure 3.1) (Public Health England, 2017o).

Figure 3.1: Number of individuals aged under 18 entering treatment in England for cannabis use, and all young drug treatment entrants, 2005/06 to 2016/17

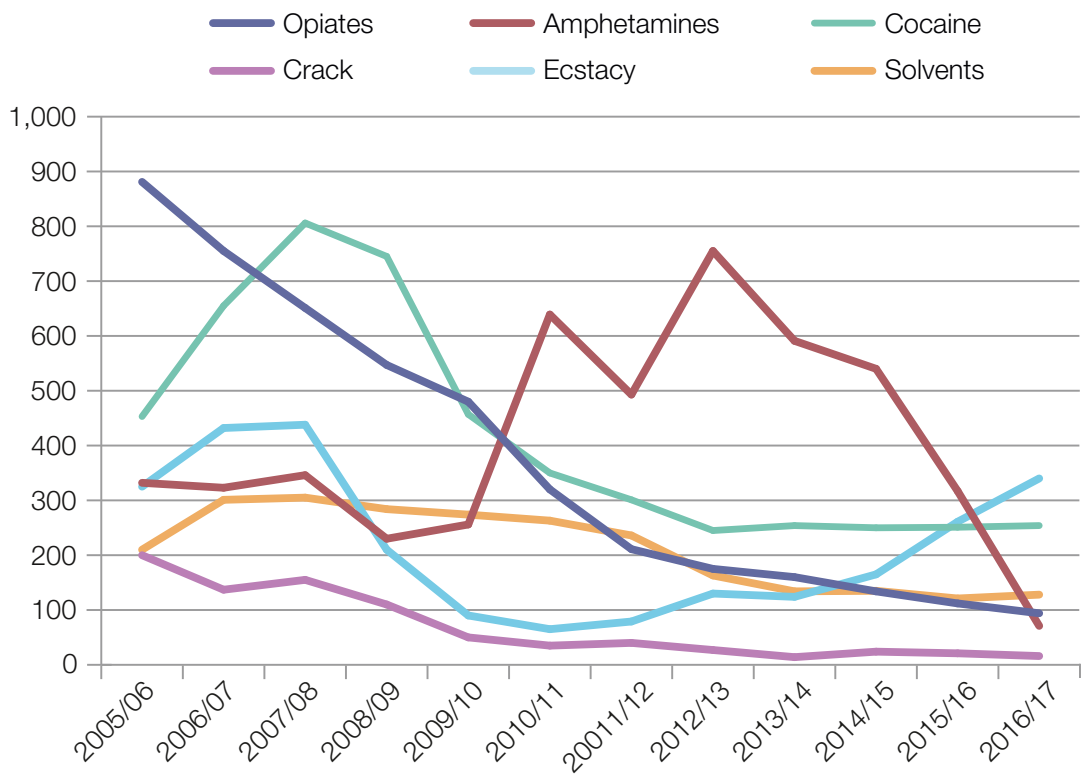


Source: (Public Health England, 2017o)

In 2016/17, the number of young people citing heroin as their primary substance fell to 71, continuing the decreasing trend since 2005/06 (the first year for which reliable data is available). In total, 94 young people cited an opioid as their primary substance in 2016/17, compared with 881 in 2005/06. The number of under-18s who were in treatment for primary powder cocaine use decreased every year between 2007/08 and 2012/13, from 806 to 245; however, this figure has remained stable for the past four years, and was 254 in 2016/17 (see Figure 3.2).

The number of young people citing amphetamine as their primary substance has fallen by more than 90% over the past four years, from 755 clients in 2012/13 to 71 in 2016/17. The number of young people in treatment for primary NPS use decreased by 49% between 2015/16 and 2016/17, from 420 to 213. Conversely, the number of treatment clients citing primary ecstasy use increased by 30% between 2015/16 and 2016/17, from 261 to 340; this number has increased greatly from the nadir of 65 clients seen in 2010/11, which coincided with the shortage of MDMA seen worldwide.

Figure 3.2: Number of individuals aged under 18 in treatment for the primary problematic use of certain Class A drugs or solvents, in England, 2005/06 to 2016/17



Source: (Public Health England, 2017o)

RisKit

The RisKit programme has been developed by the University of Kent and Kent County Council following a review of existing research and consultations with young people. This school-based programme screens young people aged 14-16 and offers interventions to those who are deemed at risk. Interventions include drug and alcohol awareness sessions, motivational interviewing and life skills training sessions. An evaluation of the programme conducted in 2014 found that it was positively viewed by both pupils and those delivering the programme (Stevens et al., 2014). Information on how to implement the programme has been made freely available on a Creative Commons licence.

3.5.2 At-risk families

Troubled Families Programme

The first phase of the Troubled Families Programme was launched by the UK government in 2012 and aimed to turn around the lives of 120,000 'troubled families' across England by May 2015 (Department for Communities and Local Government, 2012). Delivery of the Troubled Families Programme was unprecedented for an initiative of its kind in the UK in terms of the scale and pace required. Families taken on to the programme had multiple problems: children not in school; children committing crime; anti-social behaviour; parents not working; and other problems, including drug misuse.

In 2013 the government announced an expansion of the programme (phase two) to reach up to an additional 400,000 families from 2015/16. Funding totalling £900 million has been made available to meet these commitments by 2020 (Department for Communities and Local

Government, 2017). The new programme retains the focus on families with multiple problems and continues to include families affected by poor school attendance, youth crime, anti-social behaviour, unemployment and drug or alcohol misuse. The key aims of the programme include making work an ambition for all troubled families; integrating a 'whole family approach' in to local services; and helping to reduce demand for reactive services.

An independent evaluation of phase one was published in 2016 (Department for Communities and Local Government, 2016b). LAs reported monitoring data which recorded problems being experienced by families, including assessments of drug and alcohol dependency in adults and young people. Where completed information was available at entry to and exit from the programme, the monitoring data indicated a reduction in these issues for around one-third of families at exit from the programme.

The evaluation also included a family survey which contained self-reported drug and alcohol misuse questions. It compared responses from families starting the intervention with those nine months from the start of the intervention. There were no significant differences identified between the responses of these two groups in relation to their self-reported drug and alcohol use. However, a majority of the families at nine months after the intervention were identified subsequently as still receiving the intervention at the time of interview, so limited conclusions can be drawn from these findings.

Family Drug and Alcohol Courts

Family Drug and Alcohol Courts (FDACs) are specialised courts designed to work with parents who abuse substances and are involved with the child welfare system. They aim to improve children's outcomes by addressing their parents' difficulties, and parents and children are able to remain together safely during the court proceedings. The courts are able to make quick alternative placement decisions for the child if parents are unable to successfully address their substance misuse problems. Key differences between FDAC and standard care proceedings are that a dedicated judge will usually preside over all hearings in a given case, and families are supported by a specialist multi-disciplinary team which reports back to the judge on their progress.

A two-stage independent evaluation of pilots in 2008 to 2012 provided evidence that FDACs were more successful than ordinary care proceedings in helping parents overcome substance misuse in order to be reunited with their children (Harwin, Alrouh, Ryan, & Tunnard, 2014). It also found that FDACs enable parents to access and stay in treatment. These findings have been confirmed by the recently published report on the five year outcomes of FDACs. The study showed that a significantly higher proportion of mothers accessing FDACs stopped misusing drugs than mothers in the comparison group, which led to a higher rate of family reunification (Harwin et al., 2016). In 2015/16 the Department for Education (DfE) Innovation Fund helped establish the FDAC National Unit.

There are currently FDACs in England, in London, Gloucestershire, Milton Keynes & Buckinghamshire, East Sussex, Coventry, the South West Peninsula, Southampton, Kent & Medway and Leeds,[40] which are all now locally sustained. Further FDACs are expected to open, with plans to open four per year until 2020.

In January 2017 the DfE published an independent evaluation of the FDAC National Unit (Department for Education, 2017). Recommendations included: expanding the range of resource materials available to sites; increasing networking opportunities to facilitate learning; increasing communication about national research and evaluation activities; developing FDAC regional teams; and strengthening the financial sustainability of the National Unit through diverse funders.

40 See: http://fdac.org.uk/existing-sites/

The Family Nurse Partnership

Since 2007, the Family Nurse Partnership[41] has provided support to young mothers in the UK from pregnancy to the baby reaching two years old, with structured home visits by trained nurses. A randomised controlled trial looking at its effectiveness was conducted in the UK and its findings were published in October 2015. Results showed the programme had no effect on pre-natal tobacco use, birth weight, emergency department attendance and subsequent pregnancy by 24 months, which were the study's four main short-term outcomes. There were small positive impacts on some of the secondary outcomes of the study, such as maternally reported child cognitive development, language development, levels of social support and partner-relationship quality (Robling et al., 2015).

3.5.3 Other at-risk groups

Vulnerable women

Following research carried out by the Stella Young Women's initiative, the Against Violence and Abuse project produced guidelines in 2013 for engaging young women who experience domestic and sexual violence, substance misuse and mental ill-health (Against Violence and Abuse, 2013). The guidelines promote a holistic model of support.

The *Ending Violence against Women and Girls Strategy 2016-2020* (Her Majesty's Government, 2016a), published in March 2016, set out plans to tackle harm and exploitation associated with prostitution, including substance misuse.

Chemsex

In 2015, PHE published a briefing for commissioners and providers of services who work with people who engage in chemsex (Public Health England, 2015f). This includes guidance on effective practice, including targeted interventions in line with local needs, and encourages collaboration between sexual health services and community groups. The 2015/16 PHE action plan to promote the health and wellbeing of gay, bisexual and other men who have sex with men aims to increase intelligence on the prevalence of chemsex, provide support to services and reduce the availability of drugs associated with chemsex (Public Health England, 2014b).

The Mental Health Taskforce

The independent Mental Health Taskforce published the *Five Year Forward View for Mental Health* in March 2016 and set out the NHS commitments towards improving mental health care (Mental Health Taskforce, 2016). One of the key recommendations focused on the need for better integration between physical and mental health care services; for example ensuring those with severe mental illness, who are twice as likely to smoke, are signposted to smoking cessation services. It also highlighted the importance of early intervention for children and young people.

The taskforce noted the change in commissioning of alcohol and substance misuse services from the NHS to LAs, which led to the closure of specialist NHS inpatient addiction units. As a result, referral pathways have become more complex and this may have affected the provision of holistic care for those people with mental health and co-occurring substance misuse problems.

41 The Family Nurse Partnership provides support to young families (mothers aged 19 years or younger); see: http://fnp.nhs.uk/

3.6 Organisational structures and funding systems

3.6.1 Organisational structures

England

The Home Office and Department of Health and Social Care (DHSC; formerly the DH) jointly lead on the reducing demand section of the UK drug strategy (Her Majesty's Government, 2017a), which covers prevention initiatives. A new Home Secretary-chaired board will maintain oversight of the delivery of the strategy. In addition, work regarding the reducing demand strand of the strategy is captured under the Drug Strategy Implementation Group, chaired by the Home Office. This group includes representatives from a range of government departments, agencies and non-governmental organisations (NGOs) who are responsible for specific prevention initiatives both locally and nationally, including the DfE and PHE.

In April 2013, under the *Health and Social Care Act 2012* (Her Majesty's Government, 2012), LAs became responsible for the health of their constituents, with health and wellbeing boards being responsible for providing the overall strategic direction for improving wellbeing in their area (including prevention). There is no centrally mandated ring-fence related to expenditure on prevention initiatives, and consequently implementation varies between areas.

Mentor Alcohol and Drug Education and Prevention Information Service

ADEPIS was launched in 2013 with the aim of providing practitioners with advice and tools based on the best international evidence. It is run by the drug prevention charity Mentor UK, which focuses on drug harm prevention and early support. In March 2017 Mentor UK was awarded a new three year contract, jointly funded by PHE and the Home Office, for the continued development of the ADEPIS programme.[42]

Mentor-ADEPIS also manages the Centre for the Analysis of Youth Transitions (CAYT).[43] The purpose of CAYT is to develop a database of evaluations of programmes aimed at improving outcomes for young people, and to ensure that mainstream educational settings are aware of existing effective evidence-based preventative programmes. In October 2016 Mentor UK began managing Why Not Find Out,[44] an independent online source of information about drugs that also visits education and community spaces around the UK, following a merger with Angelus.

Scotland

The Scottish government works with partners, including the NHS, LAs, Alcohol and Drug Partnerships (ADPs) and drug charities on prevention initiatives. ADPs are tasked with investing in education and prevention interventions and wider family support activities, as core components of the drug treatment and support services that they provide.

Partnership for Action on Drugs in Scotland (PADS) was established in 2016 to provide collaborative leadership to continue to tackle problem drug use. It is chaired by the Minister for Public Health and Sport and includes members from health, social care and justice sectors, children's services, academia and the third sector. PADS builds on the actions set out in the *Road to Recovery* drug strategy (Scottish Government, 2008e), including better prevention of drug problems.

42 See: https://www.gov.uk/government/news/government-funds-school-resource-for-drug-and-alcohol-prevention

43 See: http://cayt.mentor-adepis.org/

44 See: http://www.wnfo.org.uk

Northern Ireland

The Northern Ireland DoH, supported by the PHA, and the Department of Education generally lead on the prevention and awareness-raising elements of the *New Strategic Direction for Alcohol and Drugs (NSD) Phase 2, 2011-2016* (Department of Health Northern Ireland, 2011). This work is overseen by the NSD Steering Group, which has input from all key partners and stakeholders. Other government departments and bodies, as well as NGOs, are responsible for specific prevention initiatives both locally and nationally.

3.6.2 Funding systems

England

LAs in England have received a ring-fenced public health grant since 2013; this has been guaranteed until April 2019. LAs are able to decide how most of the grant should be spent according to local requirements, including how much to spend on local environmental prevention initiatives. Substance misuse services for young people (which are considered prevention in the UK), along with services for adults, are paid for from public health grants.

LAs may commission prevention interventions to be delivered in state schools; however, schools may also apply independently to get funding for non-statutory initiatives from central funds.

Scotland

Responsibility for drug policy transferred from the justice to the health portfolio in 2016/17. This transfer allowed for better policy alignment and accountability within the wider health portfolio, particularly as those affected by problematic drug or alcohol use often also experience mental health and other chronic health conditions. In the financial year 2017/18, funds for the provision of drug and alcohol services are provided to health boards for onward delegation to Integrated Authorities, as constructed under the *Public Bodies (Joint Working) (Scotland) Act 2014* (Scottish Parliament, 2014). This places the obligation for all aspects of adult health and social care under one authority. It is expected that ADPs and Integration Authorities will continue to develop effective joint working partnerships to ensure the effective discharge of ADP functions, including engaging at a local level in new and emerging structures.

Wales

The Welsh government invests almost £50 million annually to deliver the commitments within the substance misuse strategy, *Working Together to Reduce Harm 2008-2018* (Welsh Assembly Government, 2008a), and its associated delivery plan (Welsh Government, 2016). Alongside the £17.1 million ring-fenced funding within the local health board budget for substance misuse services, the Substance Misuse Action Fund budget for 2014/15 stood at £32 million. Over £22 million of this funding goes directly to the seven Area Planning Boards in Wales, which support a number of projects ranging from education and prevention to treatment services.

Northern Ireland

The funding allocated to alcohol and drug prevention initiatives through the PHA has remained relatively stable over the last few years. However, a number of new services were commissioned and put in place from July 2015, including a new approach to community-based information and raising of awareness.

3.7 New developments

3.7.1 Updated prevention guideline

In February 2017 NICE published a new guideline, *Drug misuse prevention: targeted interventions (NG64)* (National Institute for Health and Care Excellence, 2017), replacing the previous guideline PH4. It provides guidance on assessment of vulnerability to drug use, delivering prevention activities, and the provision of information to adults who are vulnerable to drug misuse. An interactive overview of all NICE guidelines for drug misuse prevention was also published.[45]

The guideline provides recommendations on:

- delivering drug misuse prevention activities as part of existing services
- assessing whether someone is vulnerable to drug misuse
- providing skills training for children and young people who are vulnerable to drug misuse
- providing information to adults who are vulnerable to drug misuse
- providing information about drug use in settings that people who use drugs or are at risk of using drugs may attend, such as nightclubs, festivals or supported accommodation

3.7.2 Children and social work legislation

The *Children and Social Work Act 2017* came into force in April 2017 (Her Majesty's Government, 2017b). The main purpose of the legislation is to improve local joint working practice, in order to better safeguard children. In addition, the act:

- enables better learning, locally and nationally, to improve child protection practice
- improves support for looked after and previously looked after children
- establishes a new regulator for social work (Social Work England)
- promotes safeguarding by provision of relationships and sex education in all schools in England

The act also provides the Education Secretary with the capacity to make PSHE mandatory in all schools, following appropriate consultation.

3.7.3 Scottish legislation

In Scotland there have been multiple legislative updates including the *Smoking Prohibition (Children in Motor Vehicles) Scotland Act 2016*, which came in to force in December 2016, and the *Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016* which introduced a ban on selling e-cigarettes to those aged under 18 in April 2017 (Scottish Parliament, 2016a, 2016b). It has also been announced that new drug driving limits will be introduced by 2019. See section 3.4.2 for further information.

45 See: https://pathways.nice.org.uk/pathways/drug-misuse-prevention

3.7.4 Tobacco control

In July 2017, DH published *Towards a smoke-free generation: A tobacco control plan for England* (Department of Health, 2017b), setting out aims to achieve new national objectives by the end of 2022. The Welsh government also published its *Tobacco Control Delivery Plan for Wales 2017-2020* in September 2017 (Welsh Government, 2017). See section 3.4.4 for further information.

3.7.5 At-risk families

The UK government published a policy paper in April 2017 outlining plans to improve the support given to workless families and their children, to help them overcome complex problems they may face (Department for Work and Pensions, 2017a). *Improving lives: Helping Workless Families* includes plans to launch the next phase of the Troubled Families Programme, placing greater emphasis on helping parents with complex needs into work, and to provide greater support to help those with drug and alcohol dependencies into work, implementing recommendations from Dame Carol Black's review of employment and drug and alcohol dependency (see section 2.6.3).

3.7.6 New psychoactive substances

In October 2017, Mentor and Adfam jointly published a guide to enable and encourage parents to have effective and open conversations with children about NPS and club drugs (Mentor & Adfam, 2017). *Talking with your children about New Psychoactive Substances and Club Drugs* provides information and advice about drugs, risks of harm, approaches to staying safe and current laws, and includes suggested methods to approach discussions.

In 2016 Addaction conducted qualitative research of young people's views and opinions on NPS. Published in March 2017, the *Novel Psychoactive Substances Insight Report: "The View from Young People"* (Addaction, 2017) surveyed over 1,600 young people in order to improve the ability of health and social care services to understand and respond to young people's use of NPS. The research suggested that beyond familiar activities, which should continue, service providers need to:

- use social media, internet and phone tools to reach young people, promote the help that is available and offer them anonymised support
- work to reduce the stigma that young people feel subject to because of their NPS use
- develop NPS harm reduction messages and ensure delivery in a credible way by a range of agencies, incorporated into wider health and wellbeing support rather than activities that focus solely on the substance use
- consider how to reach young people as they are reaching a decision to stop their NPS use and provide support to help them deal with any withdrawal symptoms

3.7.7 Intelligence and evidence reviews

In March 2017, Mentor-ADEPIS published a new briefing paper, adding to the series of resources to support the delivery of effective alcohol and drug education and prevention in schools and other settings. *School-based alcohol and drug education and prevention – what works?* (Mentor-ADEPIS, 2017) synthesised evidence on why prevention should take place in schools, what

works and what does not in school-based education and prevention, and set out effective and ineffective programmes and strategies. In April 2017, Mentor-ADEPIS refreshed the *Smoking, drinking and drug use among young people*[46] online resource, providing an overview of drug use data for young people and tips for effective school-based drug education.

3.7.8 Education prevention guidance

In early 2017 the Scottish government issued qualitative surveys to LAs and ADPs to collect information and map the type of drug and alcohol education and prevention being delivered in their areas. Good practice guidance has been developed for practitioners and commissioners based on the literature review *What works in drug education and prevention* (Scottish Government, 2016f) and has been disseminated alongside the recently published Mentor-ADEPIS briefing paper, *School-based alcohol and drug education and prevention – what works?* (Mentor-ADEPIS, 2017). The findings from the mapping exercise,[47] and updated good practice guidance,[48] were published in December 2018.

3.7.9 Children affected by parental substance misuse

As part of a refresh of the Scottish government's national drug strategy *The Road to Recovery: A New Approach to Tackling Scotland's Drug Problem*, the Scottish government concluded that an area on which there needed to be continued and increased focus was children affected by parental substance misuse. A short-life working group of experts, drawn from the sector, will inform the wider strategy refresh. The Scottish government also continues to fund Lloyds Partnership Drugs Initiative to develop good practice in this area and to build capacity at a local and national level.

3.7.10 Other prevention-related publications

Through the National Child and Maternal Health Intelligence Network, PHE has published information and intelligence, including Child Health Profiles, to enable high quality and cost effective services and improve decision-making.[49] Alongside this, in June 2017 PHE issued guidance for health professionals on using statistics and other intelligence resources.[50]

In July 2017, PHE published a report collating international evidence and research on child sexual exploitation, to support local public health teams to prevent and intervene early in cases of child sexual exploitation, and to engage in multi-agency responses (Public Health England, 2017d).

The You're Welcome[51] quality standards for young people-friendly health services, first published in 2011, were refreshed as part of a project supported by PHE, NHS England and DH, led by the AYPH, British Youth Council and Youth Focus North West (British Youth Council, Association for Young People's Health, & Youth Focus North West, 2017). In 2017 a pilot of a self-assessment toolkit and a process of young people verifying services took place. The majority of the feedback was positive: 100% of pilot services said that they could see how 'You're Welcome' may improve their service, and two-thirds said the process made them consider different groups of young people and their needs.

46 See: http://mentoruk.org.uk/news/2017/04/18/smoking-drinking-and-drug-use-trends/

47 See: http://www.gov.scot/Resource/0052/00528562.pdf

48 See: http://www.gov.scot/Resource/0052/00528567.pdf

49 See: https://fingertips.phe.org.uk/profile-group/child-health

50 See: https://www.gov.uk/guidance/child-and-maternal-health-data-and-intelligence-a-guide-for-health-professionals

51 See: http://www.youngpeopleshealth.org.uk/yourewelcome/

4 Treatment

4.1 Introduction

UK drug strategies identify treatment as being effective in tackling problem drug use, and seek to improve its quality and effectiveness. Co-ordination and integration across a range of service providers is seen as key in helping problem drug users integrate into society, and all recent UK drug strategies focus on this area. Substance misuse services are commissioned by local authorities (LAs) in England; by NHS health boards in Scotland; by community safety partnerships (CSPs) in Wales; and drug and alcohol co-ordination teams in Northern Ireland. Each of these commissioning bodies receives advice and input from a number of other organisations, including Public Health England (PHE), the Public Health Agency in Northern Ireland, voluntary organisations and the police.

Community-based specialised drug treatment centres are the most common providers of substance misuse services in the UK. Treatment interventions in any given area are expected to include advice and information, care planning, psychosocial interventions, community prescribing, inpatient drug treatment and residential rehabilitation. Around one-quarter of those presenting to treatment in England during 2016 did so within prison.

In 2016 there were approximately 245,000 individuals recorded as being in drug treatment in England and Wales, with 140,000 in treatment at the start of the year, and 105,000 presenting to treatment during the year. Fifteen thousand clients presented to treatment in Scotland and Northern Ireland in 2016. More than 80% of clients in treatment at the start of the year in England and Wales (approximately 112,000 clients) cited opioids as their primary substance, and 100,000 clients were receiving opioid substitution treatment (OST). Of those presenting to treatment in the UK in 2016, just under half reported primary use of opioids, with one-quarter reporting cannabis as their primary substance.

Since 2008 there has been a steady decline in the number of new treatment presentations in England, from a peak of just over 100,000 clients to 76,000 in 2016 (excluding those presenting in prison). Between 2005 and 2016, the percentage of new presentations citing cannabis increased from 16% to 25%, while the proportion citing heroin and other opioids decreased from 65% to just over half of all presentations. The number of opioid users in prescribing treatment in England increased steadily between 2005 and 2010; however, the heroin drought that began in late 2010 saw the number of clients receiving OST decrease in 2011, and level off since then. The opioid treatment seeking population is ageing, with over one-third of those presenting for treatment in 2016 aged 40 and over.

4.2 Provision of drug treatment in the United Kingdom

4.2.1 Community-based substance misuse services

Most clients treated for problems with drug use in the UK receive treatment in a community outpatient setting. Community-based specialised substance misuse treatment centres are the most common providers of such services, and typically also provide treatment for alcohol clients. General practitioners (GPs) prescribing OST medications normally do so in a shared care arrangement with specialist services, although a few clients only see their GP.

Specialised substance misuse treatment centres are predominantly public services, commissioned and funded by local government. The contracts to deliver drug treatment services commissioned by LAs are often held by third sector organisations (ie registered charities). Some of these organisations specialise solely in substance misuse, while others deliver contracts for mental health services and services for people with learning disabilities. Specialist drug treatment services are also provided by the NHS by mental health trusts.

4.2.2 Residential and inpatient units

Residential rehabilitation services are primarily run by voluntary and private sector organisations. They offer structured programmes that may include psychosocial interventions, individual and group therapy, education and training, and social and domestic skills. There is a wide range of different types of residential rehabilitation available, and services greatly differ in terms of their philosophy, intensity, inclusion criteria, programme content and duration. The National Institute for Health and Care Excellence (NICE) guideline CG51 (National Institute for Health and Care Excellence, 2007b) recommends that residential rehabilitation be used for the "most complex users".

There are also inpatient units (often based within hospitals) which provide assessment, stabilisation and/or assisted withdrawal. Inpatient units are for those drug or alcohol users whose needs require supervision in a controlled medical environment. These units can also be attached to residential rehabilitation services or may be standalone. Inpatient detoxification interventions may also be delivered on a general ward within a hospital.

The proportion of the treatment population who receive treatment in inpatient or residential settings is low compared to those who receive it on an outpatient basis. However, it should be noted that residential services in England are not required to report treatment information on private clients to NDTMS so the number of clients treated in residential settings is underreported in treatment statistics.

Recovery house

Another non-hospital based residential setting in the UK is a recovery house. This is a residential living environment in which integrated peer support and/or integrated recovery support interventions are provided for residents who were previously, or are currently, engaged in treatment to overcome their drug and alcohol dependence. The residences are also referred to as dry-houses, third-stage accommodation or quasi-residential.

4.2.3 Prisons

Drug treatment services in prisons are commissioned on the basis of equivalence with community based treatment and underpinned by evidence-based clinical guidance. Services which are generally available in prisons include detoxification, OST, structured psychosocial interventions as well as a range of rehabilitative programmes.

4.3 Key treatment data for 2016

4.3.1 Total numbers of treatment clients

In 2016, 119,973 clients presented to treatment in the UK, including 32,197 recorded as presenting to treatment in prison.[52] Of the total, 98,057 presented to treatment in England, 12,072 in Scotland, 7,460 in Wales, and 2,384 presented in Northern Ireland. Data covering those in continuous treatment (that is, those who commenced their current treatment episode before the start of the year) as well as those presenting to treatment in the year, is available for England and Wales only. As with presentation data, treatment clients in English prisons are included in these figures. There were 244,941 individuals recorded as being in drug treatment during 2016, of which 139,424 were in continuous treatment. The majority (n=131,888) of the continuous treatment clients were in treatment in England, of which 12,880 were receiving treatment in prison in England, and there were 7,536 clients in continuous treatment in Wales (see accompanying tables 3.8 and 3.9).

4.3.2 Primary drug

Primary drugs reported by clients presenting to treatment

In 2016, half (50%; n=57,673) of all treatment presentations in the UK were for primary opioid use, with one-quarter (25%; n=29,350) of all clients presenting for primary cannabis use (see accompanying table 3.1). However, the pattern is markedly different between those reporting that they have been previously treated and those who have not, with cannabis being the most frequently reported primary drug among first ever presentations (45%, compared to 15% of those reporting previous treatment). The proportion of previously treated clients reporting primary opioid use was almost three times that of those new to treatment (63% and 22%, respectively). This is indicative of heroin clients being more likely to drop out of treatment and to subsequently re-present, or to relapse after completing a treatment episode and to seek treatment again as a result.

Cocaine was the next most commonly reported substance by those presenting to treatment, with 11% of entrants reporting powder cocaine as their primary substance, and 4.8% reporting crack cocaine. While new treatment entrants were around twice as likely to report a primary substance of powder cocaine as previously treated clients (16% and 8.1% respectively), they were less likely to report a primary substance of crack cocaine (3.4% and 5.4% respectively), indicating that crack users are also more likely to have multiple episodes. Stimulants other than cocaine were the primary substance of 3.5% of treatment entrants (with 2.2% reporting amphetamine use), and benzodiazepines were the main substance in 2.4% of cases.

Despite the association between opioid use and crime, the proportion of primary opioid clients referred to treatment through the criminal justice system (CJS) (18%) was actually slightly lower than the proportion of primary cannabis users referred through this system (21%), and the same as the proportion of cocaine users referred through the CJS (18%). For all primary substances, the most common source of referral among clients starting a new episode of treatment in 2016 was self-referral (49%).

52 Welsh data does not include those presenting to treatment in prison

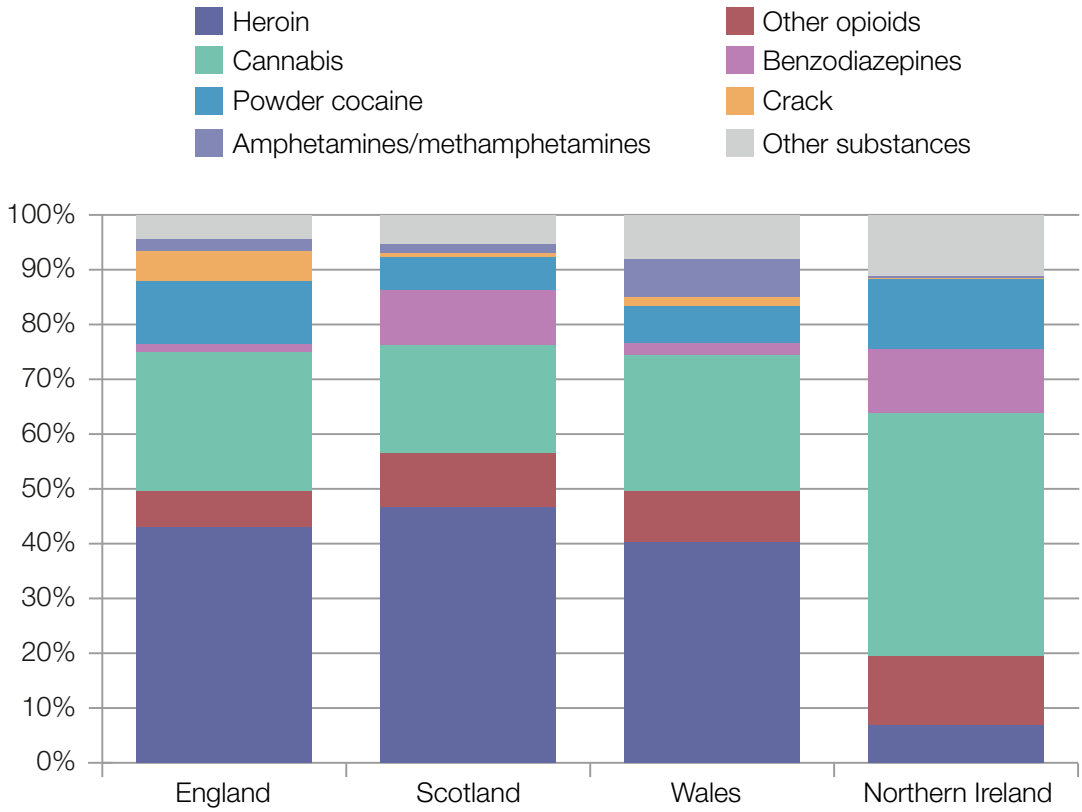
Comparisons of primary drug for clients accessing treatment across the United Kingdom

Due to its greater population size, data from the treatment system in England has a substantial influence on breakdowns reported for the UK. Analysing the presentation data by country, however, reveals a number of differences between the countries of the UK in the primary drugs cited by clients. While primary opioid use was reported by around half of all treatment entrants in England, Wales and Scotland (50%, 50% and 56%, respectively), less than one-fifth (19%) of clients starting treatment in Northern Ireland in 2016 reported primary use of these drugs (see Figure 4.1). England had almost twice the proportion of treatment entrants citing primary use of powder cocaine as Wales or Scotland (11%, 6.9% and 6.0%, respectively), and a much higher proportion of treatment entrants citing primary crack cocaine use (5.5%, 1.6% and 0.6%, respectively).

Northern Ireland reported a relatively large proportion of its treatment entrants as seeking help for drugs that are commonly prescribed as medicines. 'Other opioids' (that is, those other than heroin, methadone, buprenorphine and fentanyl) were reported as the primary substance by 11% of treatment entrants (compared to 3.3% in the UK overall), and 12% of Northern Irish clients reported primary benzodiazepine use, compared to 1.5% in England and 2.1% in Wales. These proportions are high even when taking into account the difference in proportions caused by the low number of opioid treatment seekers in Northern Ireland. Scotland also reported a high proportion of primary benzodiazepine users, with 10% of treatment entrants citing these substances.

There were also differences between the countries of the UK with respect to stimulants other than cocaine reported upon treatment entry. Wales reported the highest proportion of these clients in 2016, with 6.8% of all treatment entrants reporting primary use of amphetamines (compared to 2.0% in England, 1.6% in Scotland and 0.4% in Northern Ireland).

Figure 4.1: Proportion of clients presenting to treatment in the United Kingdom in 2016, by country and primary drug



Source: Accompanying table 3.2

Primary drug of all treatment clients (England and Wales)

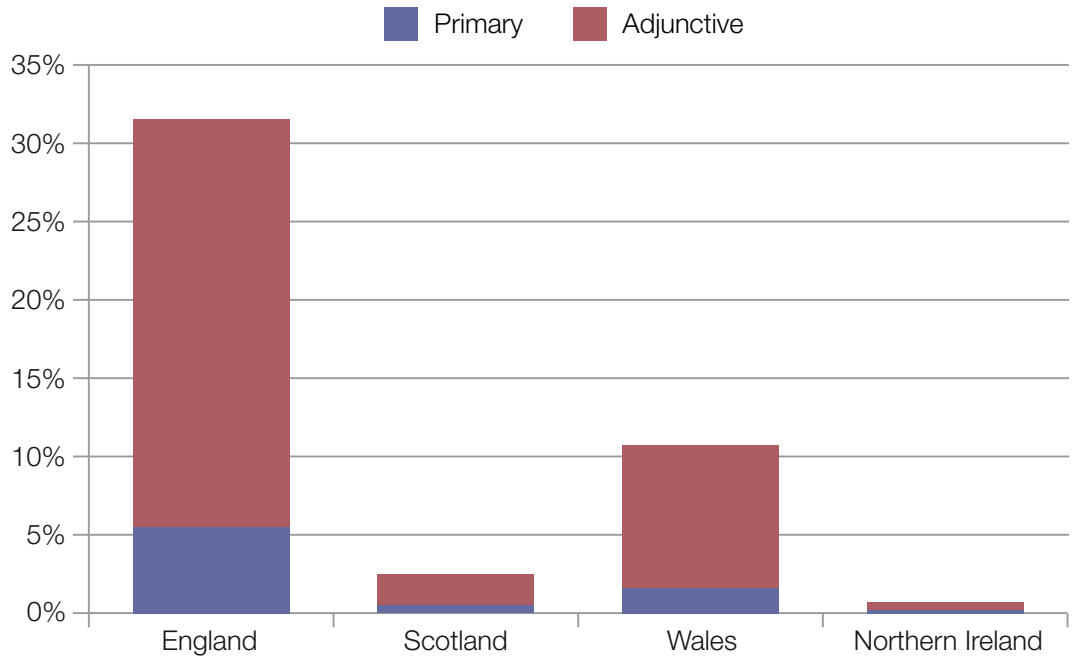
The length of time that clients spend in drug treatment differs greatly depending on the nature of the drug for which they are seeking help; in particular, opioid clients are typically in treatment for much longer than non-opioid clients. As such, the distribution of primary drug for just those clients who commence treatment in a year does not take into account those (mostly opioid) clients who have remained in treatment from the previous year. Analysis of primary drug for all those in treatment in England and Wales shows that in 2016 67% of clients were in treatment due to primary opioid use, with 59% citing heroin. Cannabis and powder cocaine were the only other primary drugs cited by more than five per cent of those in treatment (16% and 6.7%, respectively). Primary crack cocaine use was cited by 3.6% of clients; methadone was cited by 3.2% (see accompanying table 3.9).

4.3.3 Adjunctive substances

Crack cocaine

Crack cocaine was the most common adjunctive substance reported in 2016, and was reported by almost five times as many clients as an adjunctive substance (n=26,462) than as a primary substance (n=5,542). Comparing figures by country of the UK shows that crack was reported as a primary or adjunctive substance by around one-third (32%) of clients in England in 2016, three times the proportion seen in Wales (11%), and more than ten times the proportion reporting use of this substance in Scotland (2.4%) or Northern Ireland (0.7%) (see Figure 4.2).

Figure 4.2: Proportion of clients presenting to treatment in the United Kingdom in 2016 reporting primary or adjunctive use of crack cocaine, by country



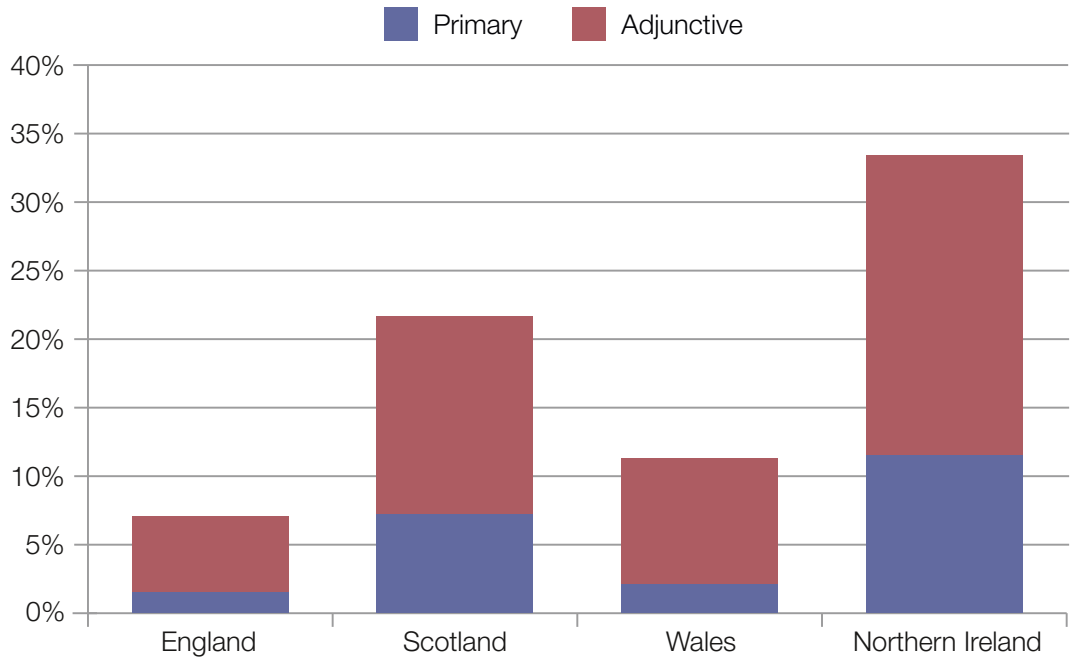
Source: Personal communication – National Drug Evidence Centre

Benzodiazepines

The number of clients presenting to treatment in the UK in 2016 reporting an adjunctive benzodiazepine problem (n=8,460) was three times the number of those reporting primary benzodiazepine use (n=2,789). Primary heroin clients accounted for two-thirds (66%) of these adjunctive benzodiazepine users. Figure 4.3 shows that as well as having the largest proportions of primary benzodiazepine clients, Scotland and Northern Ireland had the largest proportions of

treatment clients reporting adjunctive use of benzodiazepines in 2016. In total, over one-third of all treatment clients in Northern Ireland reported use of benzodiazepines (primary or adjunctive), with 22% reporting use in Scotland. Wales and England saw 11% and 7.1% of clients reporting use of these substances, respectively.

Figure 4.3: Proportion of clients presenting to treatment in the United Kingdom in 2016 reporting primary or adjunctive use of benzodiazepines, by country



Source: Personal communication – National Drug Evidence Centre

Alcohol

Alcohol was the second most common adjunctive substance reported, with primary powder cocaine clients most likely to report adjunctive use of this substance (42% of all clients). Problematic alcohol use was also commonly reported alongside crack cocaine (30%), cannabis (29%) and MDMA (28%) use. Overall, 24% of all clients presenting to treatment in 2016 reported an adjunctive alcohol problem.

Cannabis

Cannabis was the third most common adjunctive substance, after crack cocaine and alcohol. Adjunctive use of this drug was most commonly reported by those reporting primary MDMA (50%), amphetamine (34%) and cocaine use (30% of powder cocaine users and 29% of crack cocaine users).

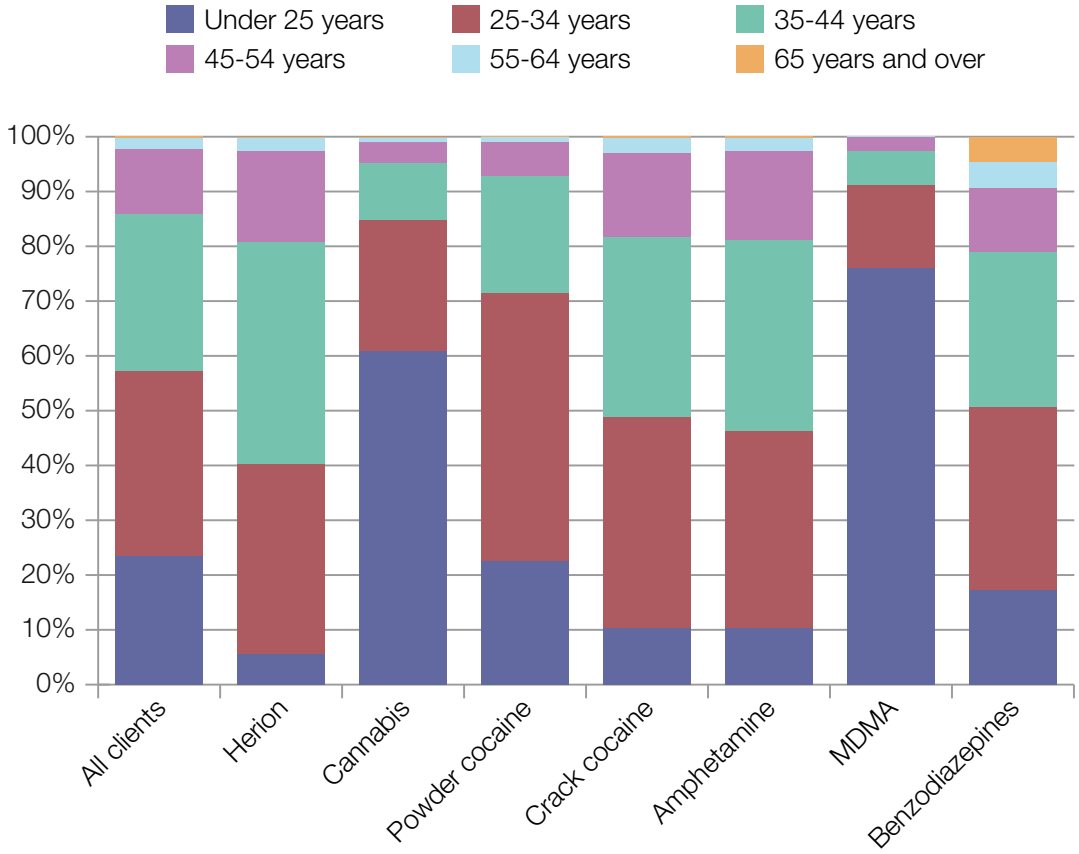
4.3.4 Current age

Age of those presenting to treatment

The mean age of all clients entering treatment in 2016 was 32.8 years, with those who had never previously received treatment tending to be younger (28.4 years) (see accompanying table 3.4). Of all clients accessing treatment, males tended to be slightly older than females (32.9 years and 32.3 years respectively); however, females that were new to treatment were more similar in age to their male counterparts (28.4 years and 28.3 years, respectively). Clients accessing

treatment for heroin, methadone, crack cocaine and benzodiazepines tended to be older than those accessing treatment for cannabis, MDMA and volatile substances (see Figure 4.4).

Figure 4.4: Proportion of clients presenting to treatment in the United Kingdom in 2016 citing primary use of certain substances, by age group

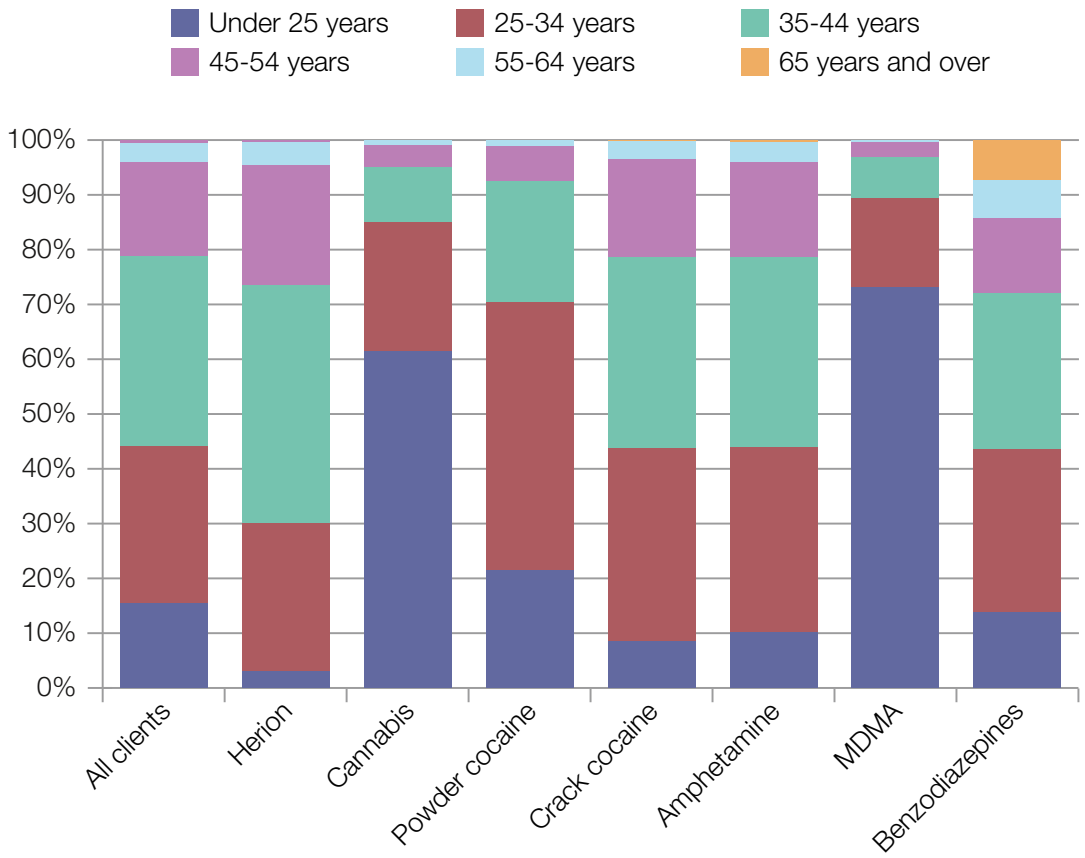


Source: Accompanying table 3.5

Age of all clients in treatment (England and Wales)

Age breakdowns for all those in treatment are available for clients in England and Wales. Over half (56%) of the 244,941 clients in treatment in 2016 were aged 35 and over. However, as clients in treatment for opioid use make up two-thirds (67%) of all those in treatment, these individuals heavily influence these age breakdowns. Excluding opioids, the majority of clients in treatment in 2016 were aged under 35 years (72%), with 40% aged under 25. Cannabis and MDMA treatment clients showed the youngest age profile, whereas those in treatment for primary heroin, crack cocaine, amphetamine or benzodiazepine use had similar age profiles with higher proportions of older clients (see Figure 4.5).

*Figure 4.5: Proportion of all clients in treatment in England and Wales in 2016 citing primary use of certain substances, by age group**



*Age group represents the age group that the client belonged to at the start of the calendar year for those in continuous treatment, and the age group that the client belonged to upon presentation to treatment for those presenting within the calendar year

Source: Accompanying table 3.11

4.3.5 Injecting status

The majority (62%) of clients presenting to treatment in 2016 reported that they had never injected drugs, with 17% reporting current injecting (see Table 4.1). Previously treated clients were three times more likely to report currently injecting than new treatment clients. Primary opioid users accounted for 91% of current injectors. Heroin users were most likely to inject, with one-third (36%) of treatment entrants citing injecting as their route of administration. Although accounting for small numbers, a high proportion of methamphetamine users (78/217; 36%) were recorded as current injectors. Due to its relatively low proportion of heroin users in treatment, clients in Northern Ireland were much less likely to have ever injected, or to be currently injecting, than those in the rest of the UK: 10% of Northern Irish clients had ever injected, with 3.1% currently injecting (see accompanying tables 3.6 and 3.7).

Table 4.1: Percentage of clients presenting to treatment in the United Kingdom in 2016 citing injecting as their primary route of administration, those reporting that they are current injectors, and those who have never injected, by primary drug

	Clients citing injecting as primary route of administration (%)	Clients currently injecting any drug (%)	Clients who have never injected (%)
Heroin	35.9%	33.4%	35.1%
Crack cocaine	3.5%	7.5%	74.2%
Amphetamine	16.9%	15.2%	65.1%
Methamphetamine	46.2%	35.9%	40.1%
Synthetic cathinones	28.4%	19.2%	58.1%
GHB/GBL	1.0%	15.7%	73.1%
All drugs	16.2%	16.5%	62.2%

Source: Accompanying tables 3.6 and 3.7

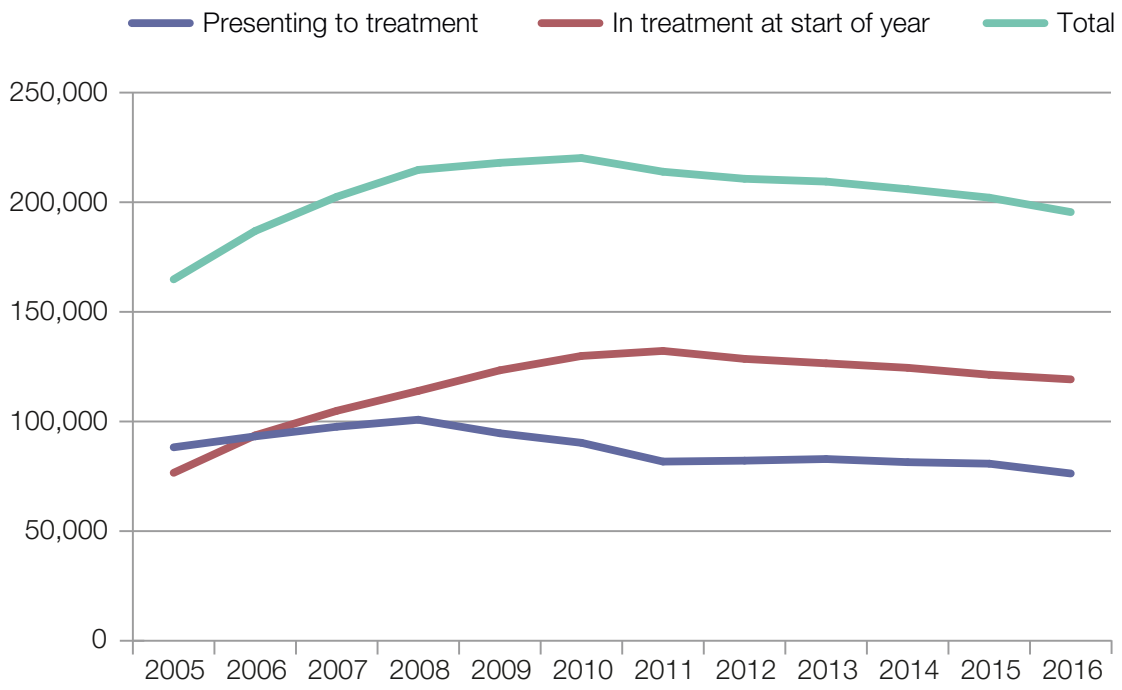
4.4 English treatment demand indicator trends

A new methodology for reporting those presenting to treatment was introduced in 2013, meaning that trends previously reported for the UK using data from before this point are not consistent with more recent UK data. Though we are not able to do so for the UK at large, we have re-analysed data from the English NDTMS from prior to 2013 using the new methodology to produce a continuous time series for English treatment data from 2005 to 2016. Data covering those in continuous treatment, ie those in treatment at the start of the calendar year, first started being reported to the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) in 2016; this information has also been extracted from the NDTMS from 2005 onwards to allow the analysis of this English time series. The figures reported in this section relate to community treatment data only, as English prison treatment data is only available from 2015.

4.4.1 Number of clients

From the start of the time series in 2005, the number of all individuals in drug treatment in England increased from 164,820 to a peak of 220,162 clients in 2010. Though reliable data does not exist on treatment numbers prior to 2005, the rise seen from 2005 is the continuation of an upward trend that is understood to have started from around 2001 when funding for drug treatment in England was substantially increased and the treatment system underwent a period of rapid expansion. The number in treatment started to fall between 2010 and 2011 at the start of the heroin drought and it has steadily decreased since, standing at 195,499 in 2016. While the number of those in treatment at the start of each calendar year shows a similar trend to the total number in treatment, the number of new presentations to treatment in each year started to decrease in 2008 (see Figure 4.6).

Figure 4.6: Number of clients presenting to treatment in the calendar year, and those recorded as being in treatment at the start of each calendar year, in England, 2005 to 2016

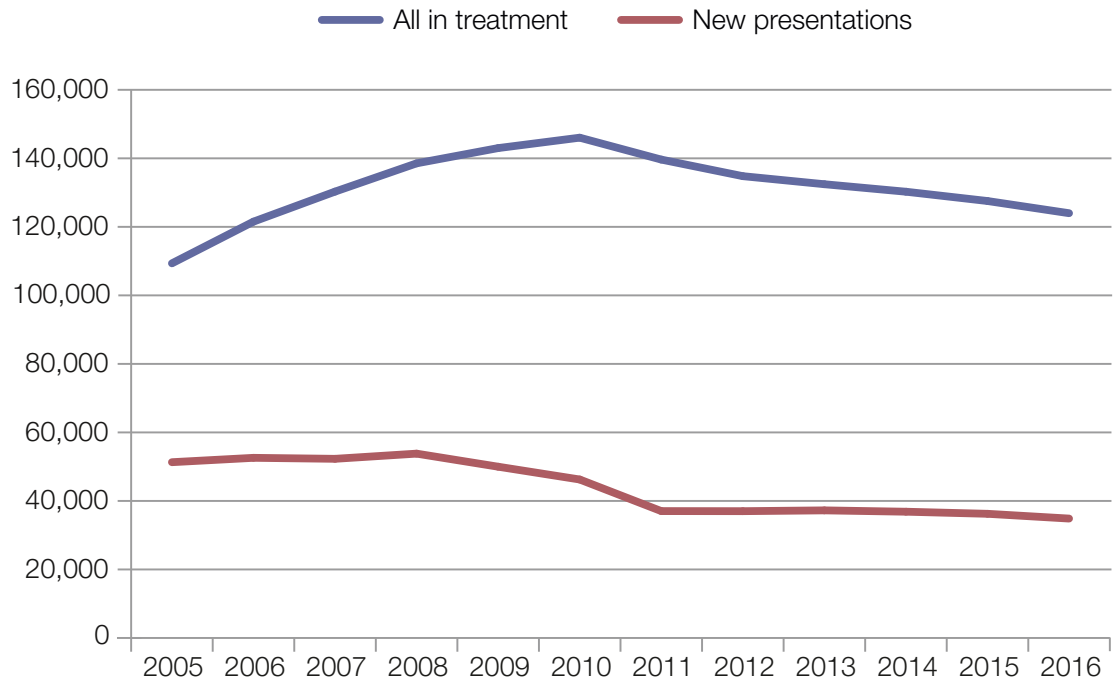


Source: Accompanying table 3.12

4.4.2 Primary drug

Heroin has remained the most commonly reported primary drug in England over the course of the time series, both for those presenting to treatment and for those in treatment at the start of the year. As such, the trends in the number of clients reporting primary heroin are very similar to the trends in the overall number of clients. A large decrease in the number of heroin clients presenting to treatment was again seen between 2008 and 2011, with this number remaining stable in the following five years; the overall number of primary heroin clients peaked in 2010 (see Figure 4.7).

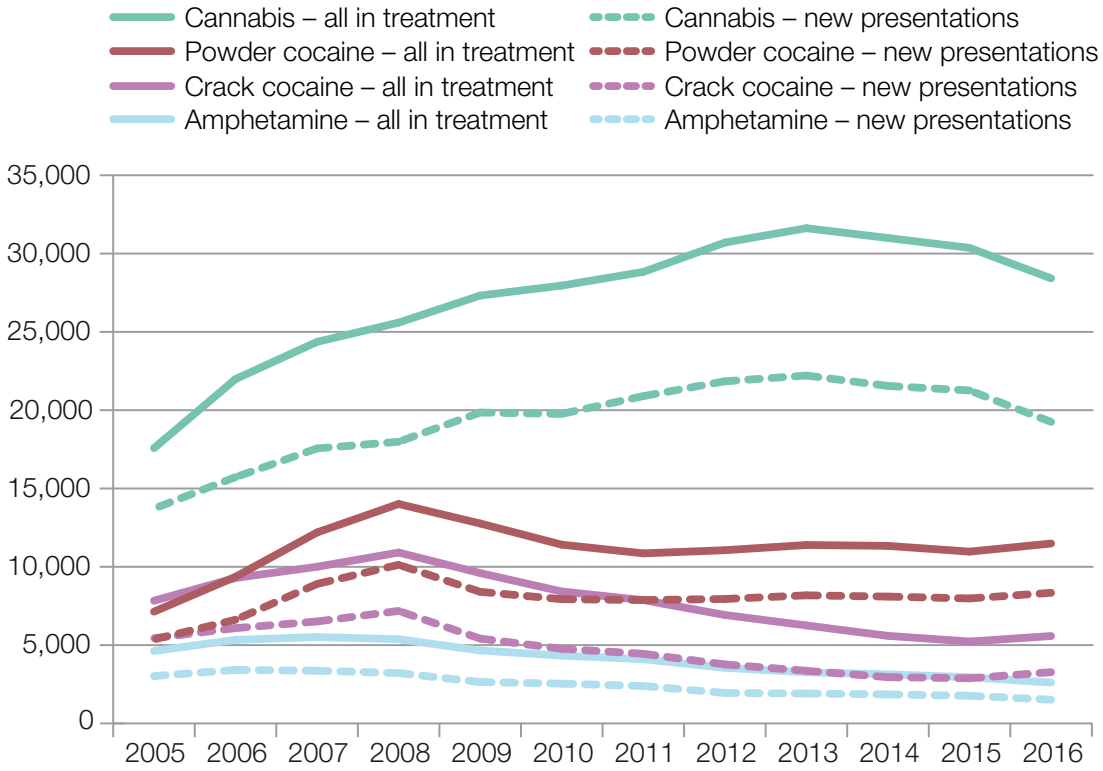
Figure 4.7: Total number of primary heroin clients in treatment, and number of clients presenting to treatment reporting primary heroin use, in England, 2005 to 2016



Source: Accompanying tables 3.13 and 3.14

Cannabis is the second most commonly reported primary drug, and the overall number of clients in treatment due to primary use of this substance increased from 17,576 in 2005 to a peak of 31,621 clients in 2013 (see Figure 4.8). The overall number of clients has fallen since then, to 28,419 clients in 2016, due to a decrease in the number of new presentations in this time; however, the number of clients in treatment at the start of each year remained relatively stable between 2013 and 2016. The number of primary powder cocaine clients has remained stable since 2010, following a peak in the total number of clients in 2008. Most primary cannabis, powder cocaine and crack cocaine clients seen within the English treatment system each year are new presentations, whereas the proportion of heroin clients that are new presentations to treatment has been less than 30% since 2011.

Figure 4.8: Total number of clients in treatment, and number of clients presenting to treatment, reporting primary cannabis, powder cocaine, crack cocaine and amphetamine use, in England, 2005 to 2016

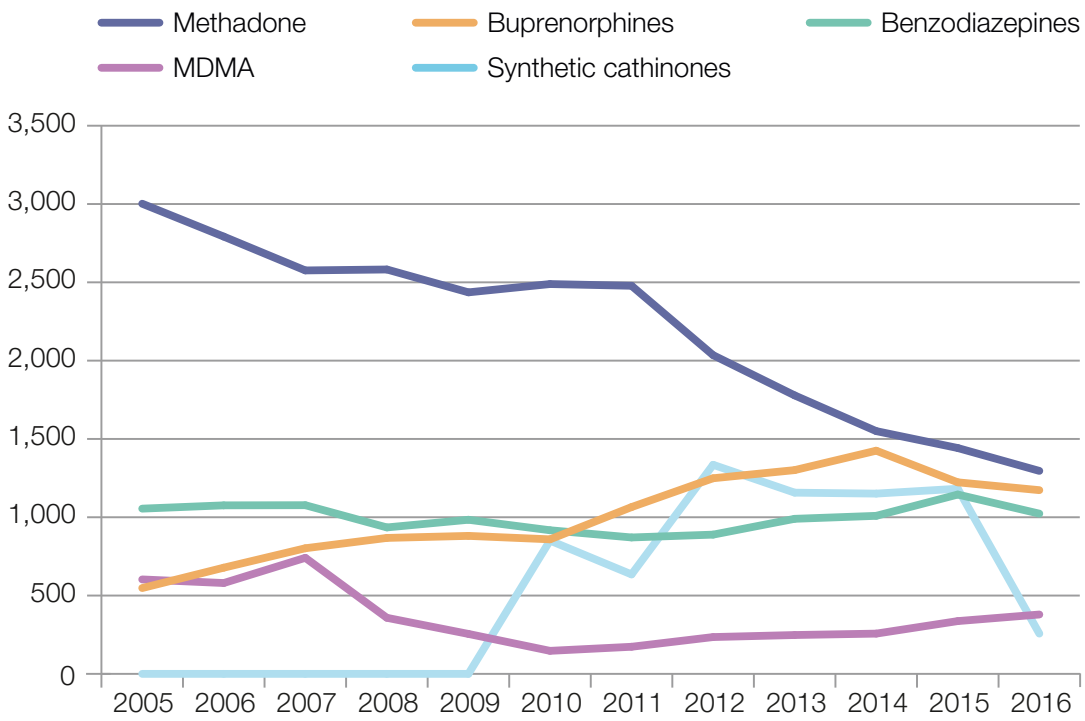


Source: Accompanying tables 3.13 and 3.14

As well as being the most common adjunctive substance for English treatment clients (see section 4.3.3 and section 4.4.4), crack cocaine has also remained the fourth most common primary substance between 2005 and 2016. The number of all clients reporting primary use of this drug almost halved between 2008 and 2015, from 10,910 clients to 5,229 clients (see Figure 4.8). However, the number of clients increased for the first time since 2008 in 2016, to 5,580, due to an increase in the number of clients presenting to treatment, from 2,883 in 2015 to 3,272 in 2016 (with increases in adjunctive use also having been observed, see section 4.4.4). This follows an increase in the estimated crack cocaine-using population in England in 2014/15 (see section 1.4.3).

Amphetamine and methadone have both seen decreases in the numbers of clients presenting for primary use of these substances over time, whereas the number reporting primary buprenorphine has increased (see Figure 4.9). The number of clients reporting primary use of MDMA decreased after 2007, at around the same time as a reported decrease in the availability of this drug. There was a dramatic fall in the number of clients presenting for cathinone use in 2016, meaning there were fewer synthetic cathinone clients than MDMA clients for the first time since synthetic cathinones were included in the NDTMS dataset in 2010. Several other indicators suggest that mephedrone use has become less common (see section 1.4.7).

Figure 4.9: Number of clients presenting to treatment in England within the calendar year, by selected primary drugs, 2005 to 2016



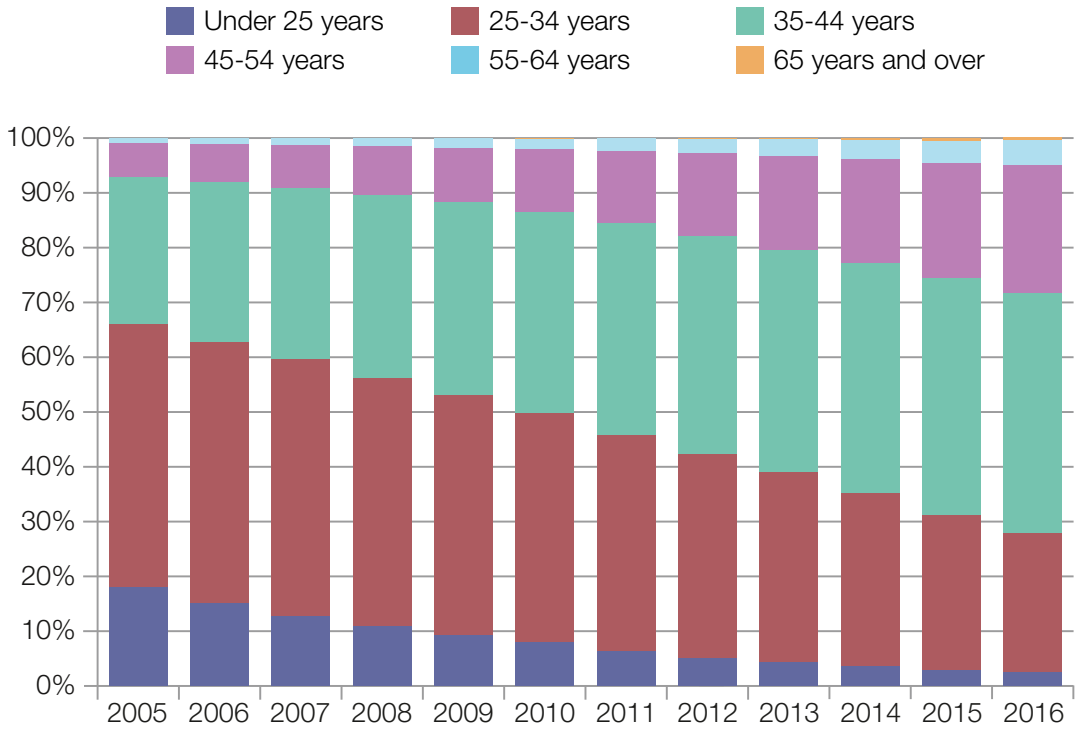
Source: Accompanying table 3.13

4.4.3 Current age and age at presentation to treatment

There has been much discussion about the ageing cohort of heroin users in the UK, an effect that has been associated with the increase in drug-related deaths involving heroin in England, Scotland and Wales over the past few years. This effect is evident in the treatment data for England from the past 12 years, which shows an increase in the proportion of primary heroin clients (both in continuous treatment and presenting to treatment) belonging to the older age groups, and a decrease in the proportion in the younger age groups (see Figure 4.10).[53] In 2005 two-thirds (66%) of heroin clients in treatment were aged under 35; however in 2016 this proportion had reduced to less than one-third (28%). Just over one-quarter (28%) of heroin clients were aged 45 years or over in 2016, compared to 7.0% in 2005.

53 Data for those in continuous treatment is for the client's current age during the calendar year; data for those presenting to treatment is for the client's age at presentation to treatment

Figure 4.10: Proportion of all primary heroin clients in treatment in England in the calendar year, by age group, 2005 to 2016*



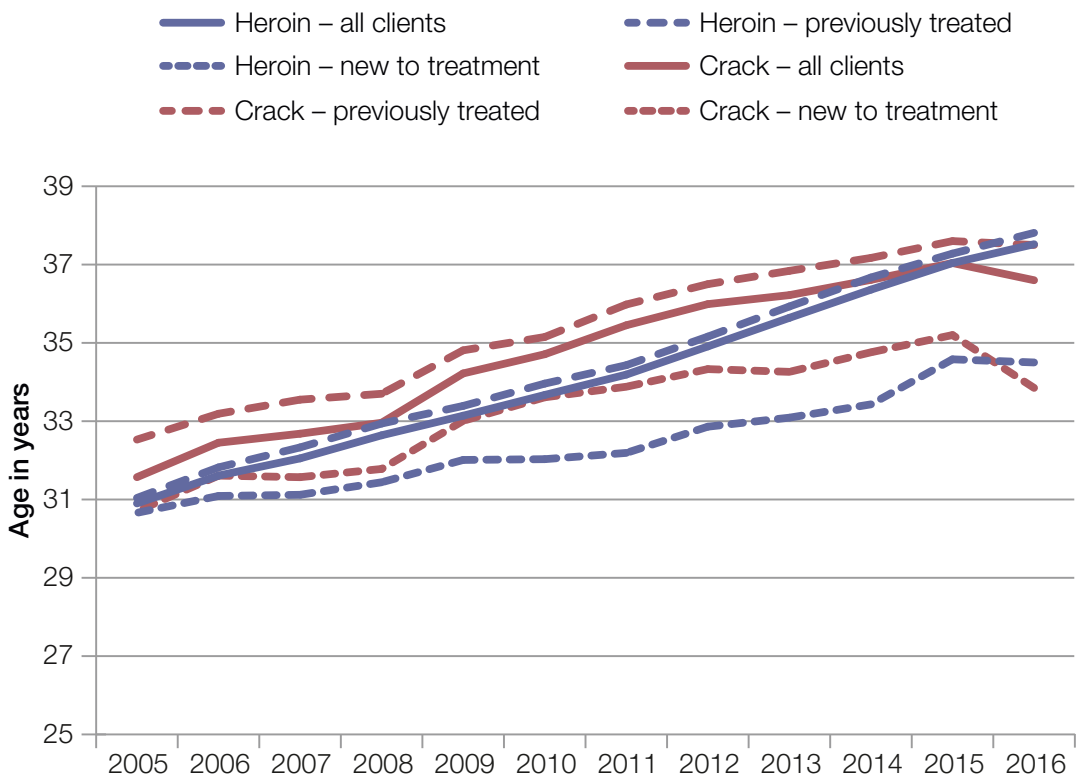
*Age group represents the age group that the client belonged to at the start of the calendar year for those in continuous treatment, and the age group that the client belonged to upon presentation to treatment for those presenting within the calendar year

Source: Accompanying table 3.16

The mean age of all clients presenting to treatment within the year has increased over time, from 29.7 years in 2005 to 32.8 years in 2016 (see accompanying table 3.15).[54] One of the main drivers behind this trend is the increasing age of those presenting to treatment reporting primary heroin use, whose mean age has increased from 30.9 years in 2005 to 37.5 years in 2016 (see Figure 4.11). Over this time period, the proportion of primary heroin clients aged 35 years or over has doubled, from 29% in 2005 to 62% in 2016.

54 Data on mean age is not available for clients in treatment at the beginning of the calendar year

Figure 4.11: Mean age of clients presenting to treatment for primary use of heroin or crack cocaine in England in the calendar year, by previous treatment status, 2005 to 2016

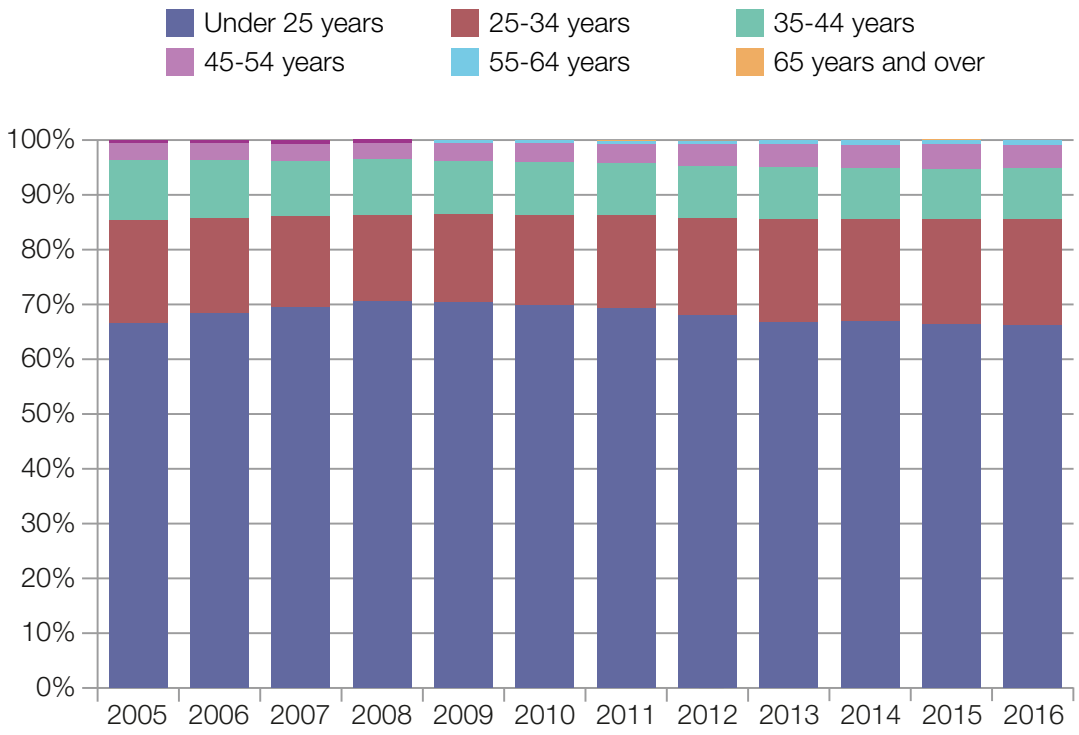


Source: Accompanying table 3.15

Primary crack cocaine users presenting to treatment have shown a similar ageing trend, from 31.6 years in 2005 to 37.0 years in 2015; however, the average age of these clients decreased in 2016 to 36.6 years. This fall was greater among crack cocaine clients that were new to treatment (from 35.2 years in 2015 to 33.9 years in 2016) than among those that had been previously treated (from 37.6 years to 37.5 years). Coupled with the increase in the number of new crack cocaine clients described in section 4.4.2, this suggests that there has been an increase in new, younger crack cocaine users presenting to treatment in England in 2016.

In comparison to heroin and crack cocaine users, the breakdown of cannabis users by age group has remained relatively static over the course of the time series (see Figure 4.12).

Figure 4.12: Proportion of all primary cannabis clients in treatment in England in the calendar year, by age group, 2005 to 2016*



*Age group represents the age group that the client belonged to at the start of the calendar year for those in continuous treatment, and the age group that the client belonged to upon presentation to treatment for those presenting within the calendar year

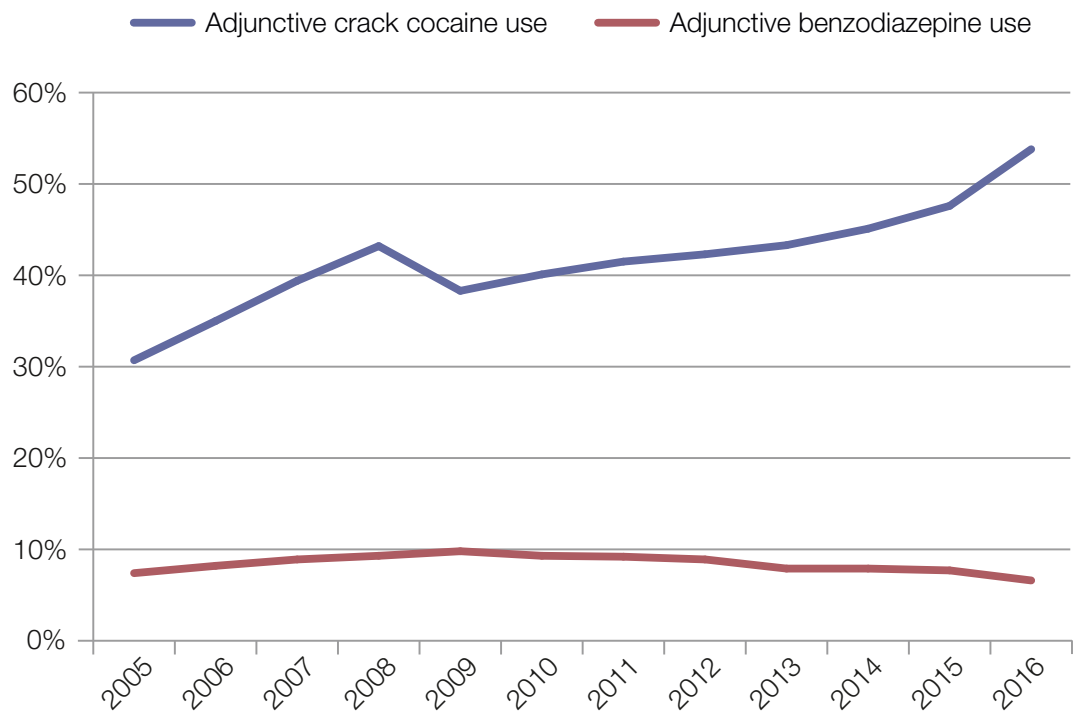
Source: Accompanying table 3.17

4.4.4 Adjunctive substances among those presenting to treatment

Crack cocaine has remained the most commonly reported adjunctive substance among all those presenting to treatment in England for the course of the time series from 2005 to 2016. Almost all clients reporting crack cocaine as an adjunctive substance are primary heroin clients; in 2016 94% of those reporting adjunctive crack use had reported primary heroin use. The proportion of primary heroin clients that also reported problematic use of crack cocaine has increased from 31% of heroin clients in 2005 to 54% of heroin clients in 2016 (see Figure 4.13). It is possible that some of the increase around the start of the time series may be accounted for by improved completion of adjunctive drug fields.

Benzodiazepines are also commonly reported as an adjunctive substance by primary heroin clients in Scotland and Northern Ireland (see section 4.3.3). However, the trend data shows that benzodiazepines have not been as frequently reported as an adjunctive substance as crack cocaine in England, and there has been a decrease in the proportion of heroin clients reporting problematic use of this class of drugs since 2009 (see Figure 4.13).

Figure 4.13: Proportion of primary heroin clients presenting to treatment in England within the calendar year reporting adjunctive use of crack cocaine or benzodiazepines, 2005 to 2016



Source: Accompanying table 3.18

4.5 Treatment outcomes

The treatment outcomes profile (TOP) is a clinical tool that enables clinicians and drug workers to keep track of the progress individuals make through their treatment journey.[55] It measures drug use and gives an early indication about a client's progress in overcoming problems with work, education or housing through a set of 20 questions.[56] TOP was introduced in England in 2007 and in Wales in 2009; however, TOP data from the two countries is not comparable due to differences in reporting methodologies.

4.5.1 Clients leaving treatment successfully in England

Adult clients

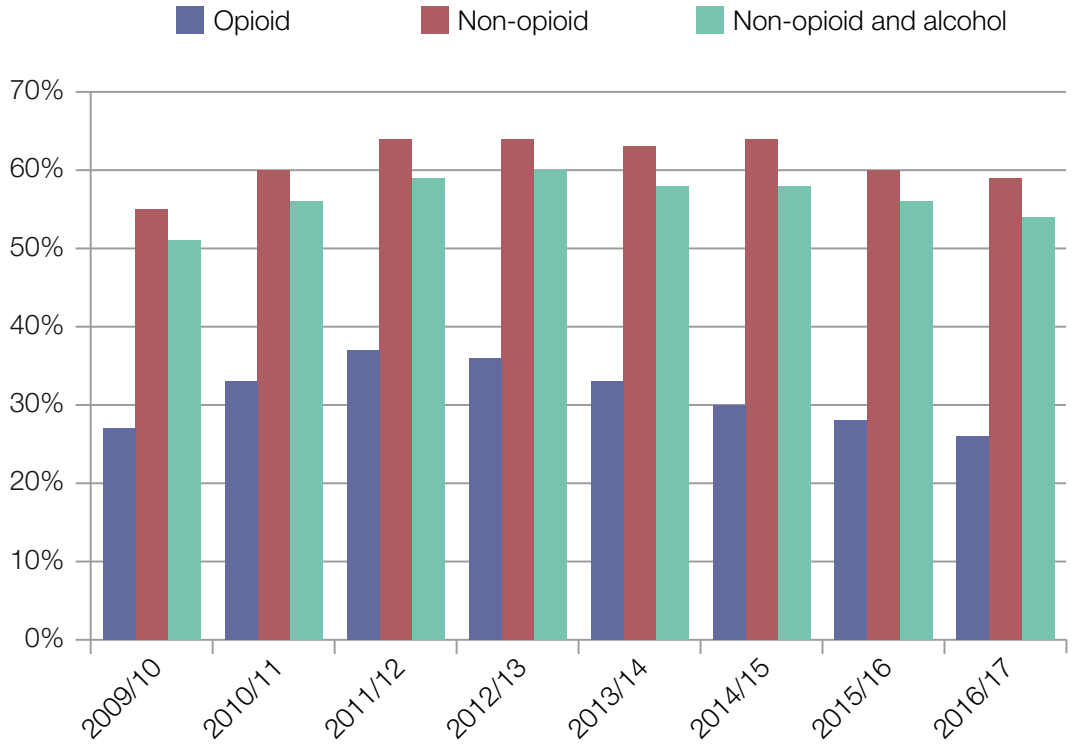
The number of opioid clients leaving treatment successfully in England was 10,439 in 2016/17 (Public Health England, 2017a). This represented 26% of those exiting treatment; the proportion of opioid clients completing treatment free of dependence has fallen from 37% in 2011/12 (see Figure 4.14). There were similar numbers of non-opioid clients who cited problematic alcohol use and non-opioid alone clients that completed treatment successfully in 2016/17: 10,035 and 10,044 respectively. Given that there were fewer overall treatment exits for each of these client groups compared to the opioid clients, the successful completion rates for these clients were substantially higher than for the opioid group (59% and 54% respectively) (see Figure 4.14).

55 A TOP assessment is completed at treatment entry and then should be completed every six months and on treatment exit

56 See: https://www.gov.uk/government/publications/drug-and-alcohol-treatment-outcomes-measuring-effectiveness

The decreasing proportion of opioid clients in treatment completing successfully may reflect a changing profile of the treatment population in relation to recovery capital, with fewer young opioid users starting treatment and many of the longer-term users with the best prospects for recovery having previously completed treatment without re-presenting.

Figure 4.14: Proportion of clients leaving treatment free from dependency in England, 2009/10 to 2016/17



Source: (Public Health England, 2017a)

4.5.2 Treatment outcomes profile data from England

Table 4.2 shows the mean number of days of use of named drugs reported at treatment start and at six month review, and the percentage of clients reporting abstinence of those drugs at review in England in 2016/17 (Public Health England, 2017a). As with other NDTMS data, the reporting methodology changed in 2014/15, and so those using non-opioid drugs are categorised according to whether they also use alcohol or not. In 2016/17 the mean days' use[57] of a drug at treatment start was highest for opioids (all opioid clients) and cannabis (without alcohol) (22.2 days and 22.3 days, respectively), followed by crack cocaine (in those also using opioids) (14.8 days), amphetamines (without alcohol) (14.4 days) and cocaine powder (without alcohol; 10.4 days). For cannabis, powder cocaine and amphetamine users, those who also used alcohol all had a lower mean days' use at treatment start, a lower mean days' use at six month review, and were as likely or more likely to be abstinent at six month review than those who did not report problematic alcohol use. Users of both opioids and crack cocaine reduced their days of illicit opioid use by less than opioid only users.

57 Self-reported use in the 28 days prior to starting treatment

Table 4.2: Self-reported drug use by treatment outcome profiles at treatment start and six month review, and the percentage of abstinent clients at six month review, in England, 2016/17

	Mean days' use of drug at treatment start	Mean days' use of drug at six month review	Percentage of clients abstinent at six month review
Opioids (all opioid clients)	22.2	8.5	39%
Crack (in those also using opioids)	14.8	7.5	40%
Powder cocaine (without alcohol)	10.4	2.5	66%
Powder cocaine (with alcohol)	9.4	2.4	66%
Amphetamines (without alcohol)	14.4	5.3	61%
Amphetamines (with alcohol)	12.0	4.0	68%
Cannabis (without alcohol)	22.3	11.4	38%
Cannabis (with alcohol)	19.3	9.5	49%

Source: (Public Health England, 2017a)

4.5.3 Treatment outcomes profile data from Wales

TOP data from Wales is given for those referred to treatment from 1 April 2009. Data published in 2017, covering those referred to treatment until 31 March 2017, showed that for those with a main problematic substance of heroin, the average number of days of opioid use fell from 22.4 at the start TOP to 8.3 at the exit TOP, representing a 63% reduction (see Table 4.3) (NHS Wales Informatics Service & Welsh Government, 2017).

Table 4.3: Self-reported drug use by treatment outcome profiles at treatment start and exit, and the percentage of abstinent clients at treatment exit in Wales, for clients referred to treatment, 1 April 2009 to 31 March 2017

	Mean days' use of drug at treatment start	Mean days' use at exit TOP	Percentage of clients abstinent at exit TOP
Opioids*	22.4	8.3	56.9
Cannabis†	22.7	14.0	28.3
Amphetamines	17.6	8.8	46.9
Cocaine	9.5	2.6	67.8

*Table shows data for opioid use by those with a main problematic substance of heroin

†There may be instances where cannabinoids have been reported as cannabis

Source: (NHS Wales Informatics Service & Welsh Government, 2017)

More than half (57%) of clients reported having not used heroin at all in the 28 days prior to the exit TOP. Reductions were greater in clients citing use of cocaine, where the average number of days of cocaine use fell from 9.5 to 2.6 (a 73% reduction). Reductions were also seen in clients who used cannabis from 22.7 days to 14.0 (a 38% reduction), with 28% not having used cannabis at all in the 28 days prior to the exit TOP. The change in frequency in the use of amphetamines between start and exit fell from 17.6 to 8.8 days (a 50% reduction), with 47% having not used amphetamines at all in the 28 days prior to the exit TOP.

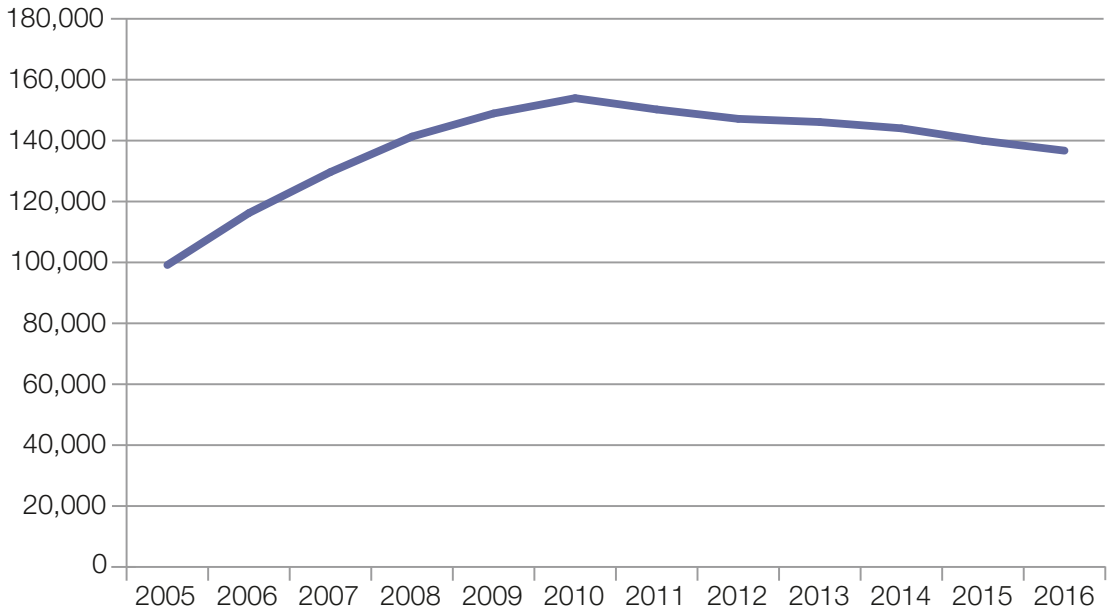
4.6 Opioid substitution treatment

In the UK, OST can be prescribed and managed by any GP, although the vast majority is received through structured treatment services where clients are encouraged to also engage in other forms of treatment such as psychosocial intervention, talking therapies and/or groups. Both methadone and buprenorphine are recommended in NICE guideline TA114 as treatment options for people who are opioid dependent (National Institute for Health and Care Excellence, 2007c). Methadone currently remains the most commonly prescribed drug for OST overall in the UK; however, in Northern Ireland methadone and buprenorphine are prescribed at similar levels.

4.6.1 England

Data from the NDTMS shows that the number of opioid users in prescribing treatment in England increased from 99,149 in 2005 to a peak of 153,939 in 2010. It has since decreased slightly, and in 2016 treatment was prescribed to 136,701 clients (see Figure 4.15 and accompanying table 3.19).

Figure 4.15: Number of clients receiving prescribing treatment in England, 2005 to 2016



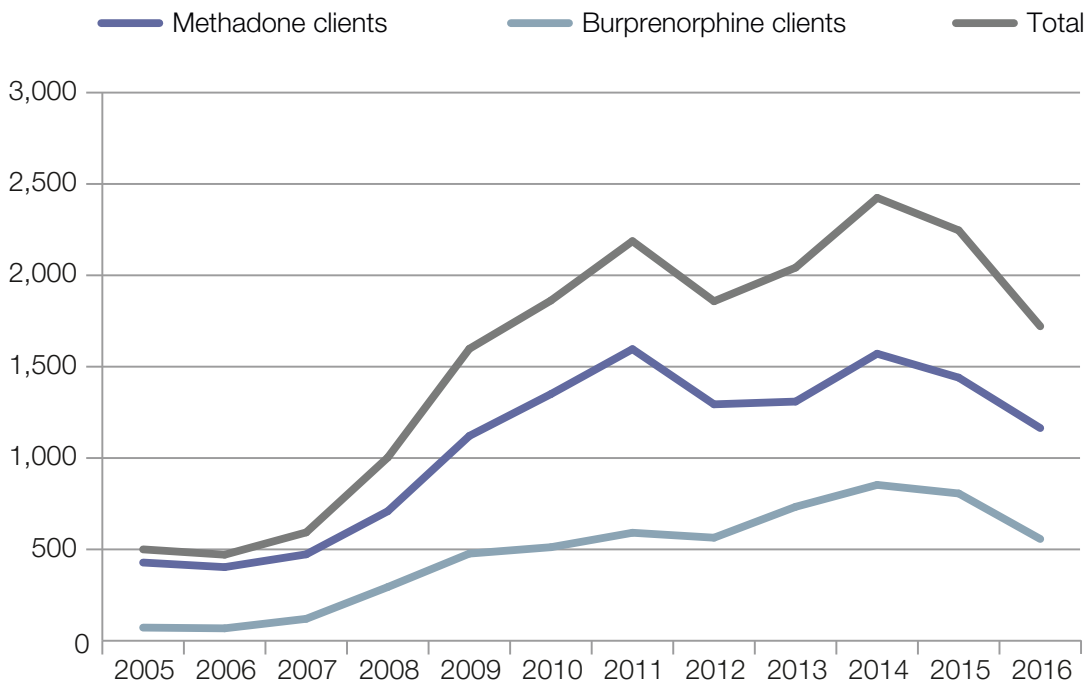
Source: Accompanying table 3.19

4.6.2 Wales

In Wales there was a steep increase in the total number of OST clients between 2005 and 2011, from 500 to 2,187.[58] Following a fall in 2012 to 1,858, the number increased again to 2,424 in 2014; however, the number has decreased over the last two years, to 1,721 in 2016 (see Figure 4.16). This pattern was largely driven by the number of clients being prescribed methadone. The number of clients receiving buprenorphine steadily increased from 72 in 2005 to 853 in 2014; this number has also decreased over the past two years, to 557 in 2016 (see accompanying table 3.19).

58 Due to changes in the Welsh dataset these figures will not match those reported in previous years

Figure 4.16: Number of clients receiving opioid substitution treatment in Wales, by treatment received, 2005 to 2016



Source: Accompanying table 3.19

Scotland

In Scotland in 2016/17, methadone 1 mg/ml solution was prescribed at least once to 26,017 individuals, based on prescriptions with a valid Community Health Index (CHI) number. Due to less than optimal CHI capture rates, this number should be treated as a minimum. In 2016/17, 98,031 (or 23%) of prescriptions did not have a valid CHI number, and it is not possible to determine how many additional individuals prescribed methadone would have been identified had this data been complete (Information Services Division, 2017b).

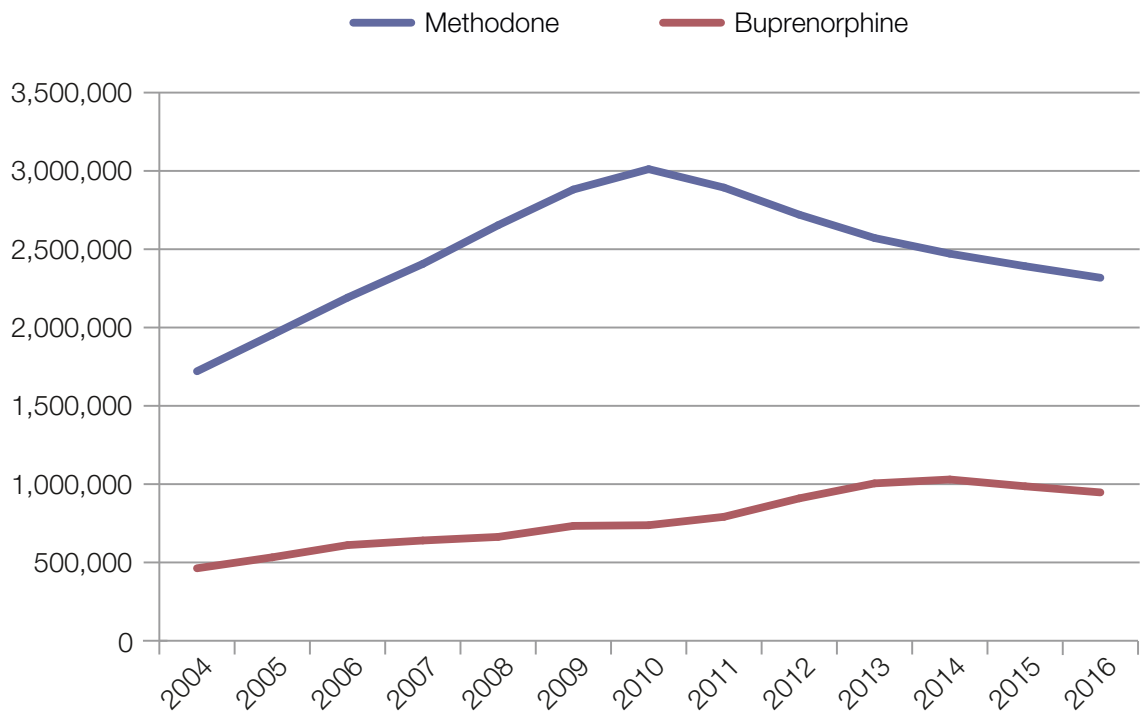
Northern Ireland

A total of 922 individuals received substitute prescribing treatment across Northern Ireland in 2015/16, a seven per cent increase on the previous year. Over two-fifths (43%) of OST clients were prescribed buprenorphine, while 42% were prescribed methadone (personal communication – Department of Health Northern Ireland).

4.6.3 Opioid substitution treatment prescribing in England

NHS Digital, formerly the Health and Social Care Information Centre, publishes annual data on the number of prescriptions, quantity prescribed and cost of all medications (in their individual formulations) that have been dispensed by pharmacies in England (NHS Digital, 2017a). The UK Focal Point has used this published data to calculate totals for methadone and buprenorphine prescribed for substance misuse going back to 2004. The number of methadone prescriptions rose by 75% between 2004 and 2010 as more people accessed OST, and retention improved. Buprenorphine prescriptions also rose over this time period, but the proportion of OST prescribing accounted for by buprenorphine fell from 21% to 20% as the increase in methadone prescribing was larger (see Figure 4.17).

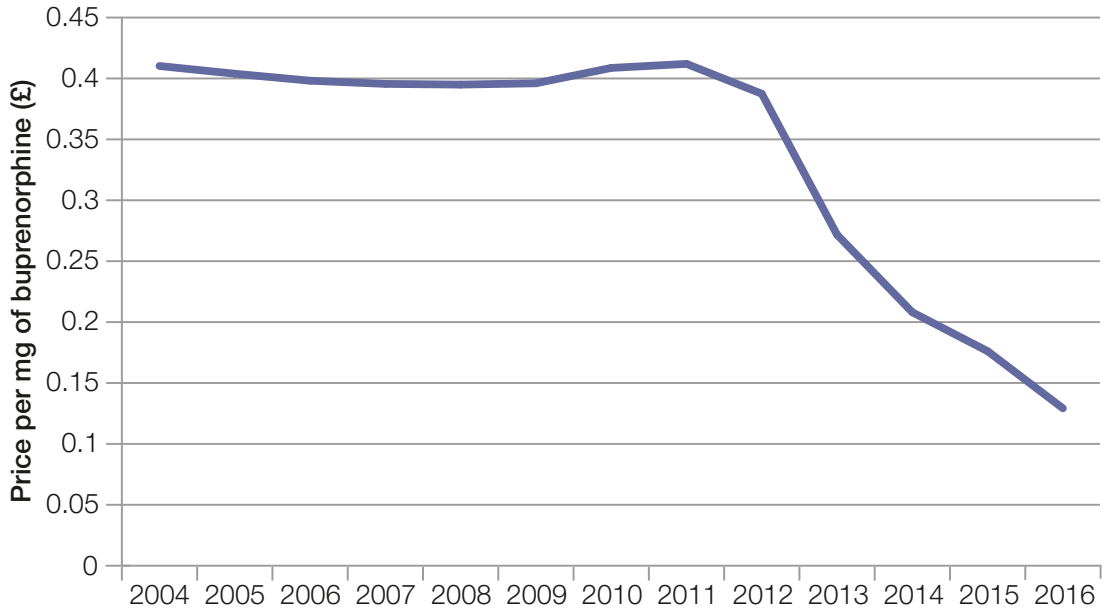
Figure 4.17: Number of prescriptions for methadone and buprenorphine dispensed in England, 2004 to 2016



Source: (NHS Digital, 2017a)

After 2010 the total number of people receiving OST fell, and there was a corresponding fall in the number of methadone prescriptions dispensed. Despite this overall fall in OST prevalence, buprenorphine prescriptions continued to rise until 2014, lifting the proportion of OST prescriptions accounted for by buprenorphine to 29%. Buprenorphine prescriptions dropped in 2015 and 2016, although the corresponding drop seen for methadone was similar, so the balance of OST medications prescribed in the English treatment system remained stable at 71% methadone to 29% buprenorphine in 2016. One possible contributing factor to the increase in the proportion of OST prescriptions accounted for by buprenorphine is the reduction in cost (see Figure 4.18).

Figure 4.18: Price per milligram of buprenorphine prescribed in England, 2004 to 2016



Source: (NHS Digital, 2017a)

4.7 Guidelines for treatment

4.7.1 Drug Misuse and Dependence: UK Guidelines on Clinical Management

In July 2017, the *Drug Misuse and Dependence: UK Guidelines on Clinical Management* were published (Department of Health, 2017a). These guidelines are an update of those published in 2007 (Department of Health England and the devolved administrations, 2007), based upon the results of a review of the evidence on drug treatment since 2007, which was conducted by an independent expert working group. A number of recent developments had prompted the decision to update the guidelines, including: a more recovery-orientated treatment system; the increasing morbidity and mortality observed within the ageing cohort of heroin-dependent treatment users; legislative changes allowing non-medical prescribers to assess, diagnose and independently prescribe for the treatment of drug dependence; changing patterns of drug use, such as decreases in people using heroin or injecting drugs, and increases in new psychoactive substances (NPS) and image and performance enhancing drugs (IPEDs); and alcohol, smoking and addiction to medicines gaining in attention.

The guidelines are to be used primarily by those providing drug treatment to people who misuse or are dependent on drugs, including medical doctors, psychiatrists, nurses, pharmacists and keyworkers. Additionally, they may also be used by those commissioning drug treatment and those considering or undergoing drug treatment. The guidelines are not intended as protocols on how drug treatment must be provided to clients; rather, professionals are expected to take the guidelines' recommendations fully into account when exercising their judgement. It is also noted that local commissioners and providers have a responsibility to develop services that enable the guidelines to be applied.

Both pharmacological and psychosocial components of treatment are covered, and other health considerations for clients who may be receiving treatment are discussed, including alcohol and tobacco use, BBVs and provision of naloxone. The guidelines contain a substantially expanded section on the provision of treatment in criminal justice settings, especially prisons, which

replaces what was separately published clinical guidance for prison drug treatment. The chapter on specific treatment situations and populations now includes issues such as NPS, IPEDs, and misuse or dependence on gabapentinoids and prescription/over the counter opioids.

4.7.2 National Institute for Health and Care Excellence guidelines

NICE produces a range of guidelines, technical appraisals and pathways relating to best practice and standards of care in the treatment of substance misuse. Interventional procedures apply to all countries of the UK. Clinical guidelines and technology appraisals apply to those using the NHS in England and Wales only and are usually disseminated after local review in Northern Ireland. Public health guidance applies to those using the NHS in England only and is often disseminated after local review in other UK countries.[59]

The key NICE guidelines relating to substance misuse treatment are:

- CG51 (2007) Drug misuse in over 16s: psychosocial interventions (National Institute for Health and Care Excellence, 2007b)
- CG52 (2007) Drug misuse in over 16s: opioid detoxification (National Institute for Health and Care Excellence, 2007a)
- CG120 (2011) Coexisting severe mental illness (psychosis) and substance misuse: assessment and management in healthcare settings (National Institute for Health and Care Excellence, 2011)
- NG58 (2016) Coexisting severe mental illness and substance misuse: community health and social care services (National Institute for Health and Care Excellence, 2016)
- NG64 (2017) Drug misuse prevention: targeted interventions (National Institute for Health and Care Excellence, 2017)
- PH52 (2014): Needle and syringe programmes (National Institute for Health and Care Excellence, 2014b)
- PH49 (2014) Behaviour change: individual approaches (National Institute for Health and Care Excellence, 2014a)
- QS23 (2012) Drug use disorders in adults (National Institute for Health and Care Excellence, 2012)
- TA114 (2007) Methadone and buprenorphine for the management of opioid dependence (National Institute for Health and Care Excellence, 2007c)

4.7.3 Project NEPTUNE

The Novel Psychoactive Treatment UK Network (NEPTUNE), an independent charity funded by the Health Foundation, conducted a systematic review of the evidence on club drugs,[60] focusing particularly on their acute and long-term harms and convened a group of UK experts to provide clinical consensus on their treatment. This evidence was then used to develop *Guidance on the clinical management of acute and chronic harms of club drugs and novel psychoactive substances* (Abdulrahim & Bowden-Jones, 2015), which was published in March 2015. Project

59 See: https://www.nice.org.uk/proxy/?sourceurl=http://www.nice.org.uk/aboutnice/whatwedo/niceandthenhs/nice_and_the_nhs.jsp

60 The term 'club drugs' is used here to refer to a group of psychoactive substances typically used in dance venues, house parties, music festivals and sometimes in a sexual context

NEPTUNE has also recently developed a series of clinical tools and an e-learning package for clinicians who come into contact with people who use club drugs and NPS.

4.8 Quality standards

4.8.1 England

The Care Quality Commission

The Care Quality Commission (CQC) is an independent body charged with monitoring, inspecting and regulating health and social care services in England. In June 2013 they conducted a consultation, *A new start* (Care Quality Commission, 2013), to examine how care services, including substance misuse treatment services based in hospitals, communities and residential rehabilitation, are monitored, inspected and regulated. Following the consultation it was proposed that five key questions should be asked of all services, asking: are they safe; effective; caring; responsive to people's needs; and well-led. Under new proposals substance misuse treatment services will be subject to expert inspections and be rated on a four point scale (outstanding, good, requires improvement and inadequate) for each of the five key questions. These ratings will be shared with service users and their families and carers, the public, treatment providers, commissioners and other stakeholders.

In July 2015 the CQC launched an inspection handbook for service providers.[61] Developed following a series of pilots, it details how inspections will be arranged and how evidence will be gathered. It also informs services how they will be rated, and the potential outcomes for those rated 'requires improvement' or 'inadequate'.

At present, the CQC generally only provides ratings for substance misuse services delivered by an NHS trust. Such services are not always included in trust ratings: their inclusion is based on specific criteria, such as whether the service represents a large proportion of a provider's activity or expenditure.

Local quality governance

While the CQC is responsible for regulating the majority of substance misuse services, a significant minority of locally commissioned services do not fall within the scope of the CQC's remit, for example community-based services where care is not provided by a listed professional. For these services, in July 2015 PHE provided guidance for LA commissioners describing what quality governance is, its importance, and setting out the responsibilities of provider organisations, commissioners and national and regional bodies to ensure that quality and safety are not jeopardised (Public Health England, 2015e).

4.8.2 Scotland

Local delivery plans

The local delivery plan (LDP) standard (formerly health, efficiency, access and treatment (HEAT) standard) for drug and alcohol treatment waiting times expects that 90% of people receive access to appropriate drug and/or alcohol treatment within three weeks of referral to support their recovery (Information Services Division, 2015a). Getting people into treatment quickly for drug-related problems is a priority for the Scottish government, as evidence suggests this is likely to result in improved client outcomes.

61 See: http://www.cqc.org.uk/content/provider-handbooks?page=1

Data is published on a quarterly basis at national, health board and ADP level. The most recent statistics, published in December 2017, indicate that in July to September 2017, 93.8% of the 10,758 people who started their first drug or alcohol treatment waited three weeks or less (LDP standard) (Information Services Division, 2017c). This ambitious standard therefore continues to be exceeded at national level.

For drug treatment, 92.6% of the 4,226 people who attended an appointment for drug treatment between July and September 2017 waited three weeks or less, similar to the same quarter in 2016 (93.6%).

For alcohol treatment, 94.5% of the 6,532 people who started alcohol treatment between July and September 2017 waited three weeks or less, similar to the same quarter in 2016 (94.2%).

Quality principles

The Scottish government has developed an alcohol and drugs quality improvement framework to ensure quality in the provision of care, treatment and recovery services, as well as quality in the data that will show the outcomes that people are achieving (Scottish Government, 2014b).

The *Quality Principles: Standard Expectations of Care and Support in Drug and Alcohol Services* have been developed to ensure that anyone looking to address their problem drug and/or alcohol use receives high quality treatment and support that assists long-term, sustained recovery and keeps them safe from harm. Fundamentally, the principles aim for a person-centred, holistic, recovery-focused approach where services and those seeking to address their problematic substance use work in partnership to achieve agreed outcomes.

There are eight overarching principles, each with a set of supporting statements and all underpinned by a recovery philosophy. The broad ethos of the principles being:

- an emphasis on high-quality, evidence-informed interventions
- workers who are appropriately trained and supervised
- comprehensive strengths-based assessments
- person-centred recovery plans that are agreed and regularly reviewed
- the opportunity for family members to be involved in recovery (if this is helpful to the individual)

Two years after the quality principles were published, the Scottish government commissioned the Care Inspectorate to lead an evaluation, consisting of a programme of validated self-assessment, to determine how well the principles had been embedded, and assess their impact on supporting ADPs to assist their clients. In November 2016 each ADP received individual reports detailing strengths and recommendations, which were developed into action plans. The overall evaluation, published in June 2017, reported that most ADPs were actively embracing and working towards implementing the quality principles, with varying degrees of success across the country. Some individuals using alcohol and drug services reported unhelpful attitudes from non-substance use services. Organisations with a role in supporting professional development across these services are to consider how they might support the necessary culture change (Care Inspectorate, 2017).

Recovery Outcomes tool

The Scottish government has developed a Recovery Outcomes tool for use by local services to record and monitor recovery outcomes of people affected by problem drug and alcohol use.

This is a peer-reviewed tool which has been developed through consultation with ADPs, drug and alcohol frontline staff, managers, service users and research groups.

The key aim of this tool is to measure changes in a person's life as a result of an intervention received when they access specialist support from drug and/or alcohol services in Scotland. The tool will help to provide a better understanding of an individual's recovery journey, related needs and motivation for change. Secondary benefits of the outcomes measurement tool are to inform workforce development, service improvement and future service provision for managers, ADPs, funding bodies and the Scottish government.

4.9 New developments

4.9.1 Treatment data from secure settings

In January 2017, PHE published their first annual report of treatment statistics from individuals in secure settings in England, covering data from April 2015 to March 2016 (Public Health England, 2017k). Data from treatment services in prisons is covered in more detail in section 5.5.1.

4.9.2 Care Inspectorate report on embedding of quality principles into the work of Alcohol Drug Partnerships

In June 2017, the Care Inspectorate published a report detailing the findings of a programme of self-assessment carried out by the 30 ADPs in Scotland, looking at how the eight quality principles had been embedded into their work, and to assess their impact on supporting ADPs to achieve better outcomes for their service users (see section 4.8.2) (Care Inspectorate, 2017).

4.9.3 Updated clinical guidelines

In July 2017, an update of the *Drug misuse and dependence: UK guidelines on clinical management* was published (Department of Health, 2017a). This followed a review of the evidence on drug treatment published since the last guidelines were issued in 2007, which was carried out by an independent expert working group (see section 4.7.1).

4.9.4 Payment by results pilot evaluation

Starting in April 2012, eight local areas of England were selected to take part in a payment by results (PbR) drug and alcohol recovery pilot. Under this programme, a proportion of payments made to treatment providers were linked to the attainment of specific outcomes by their clients, with the intent of testing and developing this approach to treatment funding. Interviews with stakeholders (including policy stakeholders, commissioners, senior managers, service managers, practitioners, carers and service users) were undertaken between April 2012 and October 2013. An evaluation comprising an analysis of data from these interviews as well as data from the NDTMS, the Police National Computer, the Office for National Statistics and Hospital Episode Statistics was published in October 2017 (Disley et al., 2017).

The evaluation found that in comparison to non-pilot sites, the performance of the pilot sites was worse in relation to the proportion of primary drug clients:

- who were assessed but failed to start treatment
- who waited over three weeks to start treatment

- who successfully completed treatment (including completion without subsequent re-presentation to treatment)
- with an unplanned discharge from treatment

Pilot sites performed better than non-pilot sites in relation to the proportion of primary drug clients:

- who reported becoming abstinent in treatment
- who injected while in treatment
- who had successfully completed treatment who didn't subsequently re-present for treatment
- who were recorded as committing acquisitive crimes

With regard to the economic impact of the PbR pilots, treatment costs were found to significantly increase in pilot sites, while there was a decrease in estimated costs associated with emergency department attendances for poisonings. However, hospital admissions for substance-related behavioural problems increased in the pilot areas.

4.9.5 Prison drug recovery wing pilots evaluation

An evaluation of the prison drug recovery wing pilot scheme was published in October 2017 (Lloyd, Page, McKeganey, Russell, & Liebling, 2017). The pilots were run in ten prisons in England and Wales in 2011 and 2012, with the intention of delivering abstinence-focused recovery services within the prison. The results of the evaluation are covered in section 5.9.3.

4.9.6 Individual placement and support trial

In November 2017, PHE announced seven LA areas that will be taking part in a randomised controlled trial of individual placement and support (IPS) for people dependent on either drugs, alcohol or both who are in community treatment services. The trialling of IPS approaches for those in drug treatment was recommended by Dame Carol Black in her report *An independent review into the impact on employment outcomes of drug or alcohol addiction*, and obesity (Black, 2016). The pilot will be funded by the joint Department for Work and Pensions, and Department of Health Work and Health Unit, and is to be run by PHE.[62]

4.9.7 Guidance on co-occurring mental health and substance misuse

Research shows that mental health and substance misuse problems often co-occur, and it has been found that individuals with co-occurring problems have been excluded from services when they have needed to access them. In June 2017, PHE published *Better care for people with co-occurring mental health, and alcohol and drug use conditions* (Public Health England, 2017c), guidance for commissioners and providers of mental health and alcohol/drug treatment services to inform the commissioning and provision of effective care for people with co-occurring mental health and substance misuse problems. The guidance aims to encourage commissioners and providers to work together to improve access to services in order to reduce harm, improve health and enhance recovery.

62 See: https://www.gov.uk/government/news/phe-announces-areas-for-ips-alcohol-and-drug-dependency-trial

5 Drug users in prison and the broader criminal justice system

5.1 Introduction

Those who come into contact with the criminal justice system (CJS) often have a history of substance use. Survey data suggests that the majority of prisoners have used illicit drugs prior to imprisonment, with a large proportion indicating that drugs were a problem for them while in the community. Cannabis is the most prevalent 'traditional' drug of misuse both outside and inside of prison; other sedative drugs such as heroin, buprenorphine and benzodiazepines are also commonly reported to be used in prison. Surveys and analytical data suggest that new psychoactive substances (NPS), in particular synthetic cannabinoid receptor agonists (SCRAs), are now used at a similar level to cannabis in prison, and the rise in their use has been associated with a number of serious issues, including debt, violence, self-harm and death.

Drug strategies focus on the treatment and recovery of prisoners with substance misuse problems, in order to reduce the demand for these substances in prisons. Prisoners have access to a range of treatment services including clinical services such as detoxification and opioid substitution treatment (OST), structured psychosocial interventions, case management and structured talking therapies. Blood-borne viruses (BBVs) remain a cause for concern; to improve the detection, surveillance and management of these infections, opt-out BBV testing has been introduced in prisons in England, Wales and Scotland. Take-home naloxone (THN) is widely available in Scotland and Wales for prisoners at risk of opioid overdose on release, while provision in England is relatively sporadic. Drug recovery wings/units have also been piloted in England, Wales and Northern Ireland. Decreasing the supply of drugs into prisons has been a priority. New technology has recently played a part in both the supply side (for example drones being used to fly drugs into prison) and in the work to detect drugs being smuggled into prisons (such as the use of body scanners).

Rehabilitative and treatment opportunities are made available to those who need them at other stages of the CJS (police station, court, community sentence) on a voluntary basis and as part of a court-mandated sentence or post-release licence. Strategies have highlighted the importance of continuity of drug treatment for offenders once they leave prison establishments, and contact with drug treatment services upon release is now mandatory for some offenders.

5.2 Prison service overview

Prison services in the UK are managed by three separate authorities: England and Wales; Scotland; and Northern Ireland. There are currently 137 prison establishments in the UK, holding approximately 94,000 adult (89,750 male and 4,250 female) and 1,250 young offenders.

5.2.1 England and Wales

The Ministry of Justice (MOJ) has departmental responsibility for the 119 prisons in use in England and Wales. The majority (105) of these are run by Her Majesty's Prison and Probation Service (HMPPS), while the remaining 14 prisons are contracted out to private companies. Eleven establishments out of the 119 are predominantly for female prisoners, seven are young offender institutions (YOIs), one is a secure training centre, and two are immigration removal

centres (Her Majesty's Prison and Probation Service, 2017). Six of the all-male prisons are located in Wales; Wales does not have any prisons holding only females. On 29 December 2017, the England and Wales adult prison population was 84,746, with 80,794 male and 3,952 female inmates.[63]

When sentenced, adult male prisoners are assigned to a security category[64] and allocated to the appropriate prison. There are multiple types of prison operating throughout England and Wales, designed to accommodate prisoners while they are on remand and post-conviction. The main categories of prison include:

- local – serve the courts and receive remand and post-conviction prisoners before their allocation to other establishments
- resettlement – expected to hold category C prisoners who will engage with resettlement providers in the last three months of their sentence
- training – offer courses and training as part of prisoner rehabilitation
- open – accommodate category D prisoners as well as indeterminate and longer-sentenced prisoners who are coming towards the end of their sentence. Open prisons are part of the resettlement programme
- high security – may be local or dispersal prisons. Core locals primarily serve the courts and the majority of their population are those described in the local prison section above. Dispersal prisons serve to spread the category A population around the country, preventing high risk prisoners from being concentrated in one establishment, thereby reducing the risk associated with holding them

Prisons may have dual functions; for example local prisons may also serve as resettlement prisons.

5.2.2 Scotland

The Scottish Prison Service (SPS) is an executive agency of the Scottish government, and delivers custodial and rehabilitation services to those offenders sent to it by the courts. There are currently 15 prisons within the Scottish prison system. Thirteen are publicly managed and two prisons, Her Majesty's Prisons (HMPs) Addiewell and Kilmarnock, are operated by private sector companies under contract to the SPS. In general, the composition of the populations of Scottish prisons are more mixed than those in England and Wales, with a number of prisons holding prisoners on remand, short- and long-term offenders, life sentence and extended sentence offenders. Scotland has one open prison, HMP Castle Huntly, and HMP Addiewell is designated as a learning prison.

As of August 2017, the available design capacity for prisons in Scotland was for 7,918 prisoners (personal communication – Scottish Prison Service). The average daily adult prisoner population during 2016/17 was 6,727 male and 304 female prisoners. In the same year, the average YOI population (aged under 21) was 521 inmates (458 males, 63 females). In total, the average daily prisoner population in Scotland in 2016/17 was 7,552 (Scottish Prison Service, 2017b).

63 See: https://www.gov.uk/government/statistics/prison-population-figures-2017

64 Security categorisation is based on the level of risk a prisoner might pose to the public or national security should they escape, and the likelihood of their making attempts to do so. Category A prisoners pose the highest security risk; category D prisoners pose the lowest risk

5.2.3 Northern Ireland

In Northern Ireland there are three publicly-run prison establishments: HMP Maghaberry, a modern high security prison holding adult male prisoners; HMP Magilligan, a medium-to-low security institution also holding adult male offenders; and HMP and Young Offenders' Centre Hydebank Wood College and Women's Prison, which holds male young offenders and female prisoners of all ages.

In December 2017 the prison population of Northern Ireland consisted of 1,416 inmates: 53 adult females, 1,278 adult males and 85 young offenders (three female and 82 male) (Northern Ireland Prison Service, 2018).

5.3 Drug use in the prison population

5.3.1 Drug use prior to imprisonment

The majority of the data regarding prevalence of drug use prior to imprisonment comes from self-reporting by prisoners as part of repeated prison surveys. In one survey, around two-fifths of prisoners in England and Wales reported using cannabis in the two months prior to imprisonment, with cocaine (29%) and heroin (15%) also commonly reported (see Table 5.1) (Her Majesty's Inspectorate of Prisons, 2015). In Scotland, further information is available from addiction prevalence tests (APTs), carried out during one month of the year, where offenders are tested for a number of substances on reception to, or at liberation from, prison. APT results showed that 76% of prisoners tested positive for an illicit drug (including illicit use of medications) on reception to prison in 2016/17 (Scottish Prison Service, 2017a). Cannabis was again the most commonly detected drug (47% of samples); however, benzodiazepines were found in 41% of samples, a greater proportion than opioids (33%) and cocaine (20%). In England, a screening programme carried out in ten prisons across the north-west of the country in 2014 and 2015 found that 58% of prisoners on first reception to prison tested positive for traditional drugs of misuse, with cannabis (25%), cocaine (25%) and heroin (17%) most commonly detected (National Offender Management Service & LGC, 2017). High levels of certain prescribed medications were also found, in particular benzodiazepines, present in 22% of on-reception samples.

Around 30-40% of prisoners report that their drug use is problematic prior to imprisonment (Her Majesty's Inspectorate of Prisons, 2015; Scottish Prison Service, 2015a). Female prisoners appear to be more likely to report having a problem than male prisoners: 41% of female respondents to a survey in England and Wales reported having had a problem with drugs on arrival in prison, compared to 27% of male respondents (Her Majesty's Inspectorate of Prisons, 2015), echoing a recent study that found a higher prevalence of drug use disorders in female prisoners worldwide (Fazel, Yoon, & Hayes, 2017).

Table 5.1: Proportion of prisoners self-reporting or testing positive for use of selected drugs prior to imprisonment, England & Wales and Scotland

	England & Wales (survey) 2015[a]	North-west England (testing) 2014/15[b]	Scotland (survey) 2015[c]	Scotland (APT) 2016/17[d]
Any drug	52%	58%*	–	76%
Cannabis	38%	25%	–	47%
Heroin	15%	17%	–	33% (opioids)
Buprenorphine	–	5%†	–	10%
Benzodiazepines	–	22%	–	41%
Cocaine	29%	25%	–	20%
Amphetamines	9%	8%	–	2%
NPS	5%‡	2%‡	27%§	–
SCRAs	6%	9%	16%	–

a Drugs used in the two months prior to imprisonment

b Positive test on reception to prison (both from the community and from other prisons)

c Ever used 'legal highs' (including SCRAs) prior to imprisonment

d Positive test on arrival at prison

*Those testing positive for traditional drugs, excluding medications and NPS

†Includes those prescribed buprenorphine for OST

‡Non-SCRA NPS

§NPS including SCRAs

Source: (Her Majesty's Inspectorate of Prisons, 2015; National Offender Management Service & LGC, 2017; Scottish Prison Service, 2015a, 2017a)

5.3.2 Drug use inside prison

Prevalence of drug use inside prison is self-reported in surveys, and in-prison testing data has been published for England & Wales and Scotland. As expected, the level of drug use in prison is lower than in the community, with a shift away from stimulants to sedative drugs. Surveys suggest that cannabis is the most prevalent traditional drug of misuse inside prison as well as outside, with 10-15% of respondents reporting use inside prison (see Table 5.2) (Her Majesty's Inspectorate of Prisons, 2015; Scottish Prison Service, 2015a); however, testing data suggests a slightly different picture. SCRAs were the most commonly detected 'substance' in pre-release samples in the north-west England testing study carried out in 2014 and 2015, detected in 16% of samples (National Offender Management Service & LGC, 2017). Buprenorphine (not prescribed to the prisoner) was the most common substance found at liberation in Scottish APTs in 2016/17 (12% of samples) (Scottish Prison Service, 2017a). Interestingly, SCRAs were the only substance to increase in prevalence in prisons compared to the community in the north-west prison study, having been found in eight per cent of samples on reception to prison from the community. Other surveys have suggested an even higher prevalence of SCRA use, with one reporting last month use of SCRAs at 33% among its respondents (User Voice, 2016). Heroin use appears to halve in prison, from around 20% of prisoners using this substance prior to reception to less than 10% in prison (Her Majesty's Inspectorate of Prisons, 2015; Scottish Prison Service, 2015a, 2017a).

Table 5.2: Proportion of prisoners self-reporting or testing positive for use of selected drugs during imprisonment, England & Wales and Scotland

	England & Wales (survey) 2015[a]	North-west England (testing) 2014/15[b]	Scotland (survey) 2015[c]	Scotland (APT) 2016/17[b]
Any drug	18%	10%*	24%	30%
Cannabis	13%	5%	15%	9%
Heroin	7%	3%	8%	9% (opioids)
Buprenorphine	9%	5%†	9%	12%
Benzodiazepines	4%	9%	9%	6%
Cocaine	4%	1%	3%	1%
Amphetamines	1%	1%	4%	0%
NPS	5%‡	0.1%‡	11%§	–
SCRAs	10%	16%	9%	–

a Ever used drugs in the prisoner's current prison

b Positive test on release from prison

c Used illegal drugs in the last month while in this prison; ever used NPS in prison

*Those testing positive for traditional drugs, excluding medications and NPS

†Includes those prescribed buprenorphine for OST

‡NPS excluding SCRAs

§NPS including SCRAs

Source: (Her Majesty's Inspectorate of Prisons, 2015; National Offender Management Service & LGC, 2017; Scottish Prison Service, 2015a, 2017a)

Mandatory drug testing is carried out in prisons in England and Wales, and can be undertaken in one of five ways: random; reasonable suspicion; risk assessment (where prisoners are being considered for a privilege or position of trust, such as release on temporary licence); frequent test programme (due to previous history of drug use); or reception testing (prisoners selected on a routine or occasional basis). In 2016/17, 9.3% of mandatory drug tests were positive (National Offender Management Service, 2017); a 21% increase on the rate for the previous year of 7.7%, and a 35% increase from 2014/15 (6.9%) (National Offender Management Service, 2015). Due to their recent emergence, and the large number of SCRA compounds that may be found in synthetic cannabis products, SCRAs were only included in routine in-prison drug testing programmes in September 2016, therefore these figures do not include detections of SCRAs.

5.3.3 Drug supply in prisons

Drug supply into prisons

Interviews with prison staff, and prisoners who have participated in the drug market in prison, have previously identified visits, the postal system, new receptions, staff and transfer over the prison perimeter as the most significant methods of delivering drugs into secure settings (Penfold, Turnbull, & Webster, 2005).

More recently, Ralphs et al looked into the establishment of the SCRA market within a category B local prison in England, prompted by an increase in the number of seizures of SCRAs within this establishment and the occurrence of serious incidents within the prison relating to SCRA use (Ralphs, Williams, Askew, & Norton, 2016). Analysis of security reports and interviews with prisoners and staff suggested that the methods outlined above still play a role in how drugs are supplied in prison. The research also highlighted new developments, the most significant of these being the use of licence recall. Under this system, individuals who have served more than one day in prison are released on a minimum 12 month licence or parole with certain conditions associated. If the offender commits or is charged with a further offence during this time, or if their offender manager (probation officer) believes that they are likely to offend during their licence period, they can be recalled to serve further time in custody. The authors found that rather than acting as a deterrent, the licence recall system meant that released offenders could 'plug' themselves with SCRAs and subsequently break the terms of their licence in order to get recalled, allowing them to bring SCRAs back into prison to sell. In some cases, recall may follow something as simple as missing a probation appointment.

Ralphs et al also confirmed that drones play a part in the delivery of drugs into prison, a method which has been previously identified by the MOJ. In response to this development, the MOJ announced the formation of a specialist squad of prison and police officers which will work with HMPPS and law enforcement agencies in identifying those involved in smuggling drugs into prison this way.[65]

Another method of getting SCRAs into prison establishments uses the fact that they are available in a liquid form. The liquid can be sprayed onto paper, sent into the prison via the postal system, and can then be torn into pieces and smoked. Different forms of paper items have been reported to be used, including children's drawings and bogus legal correspondence. This last method poses a particular challenge for governors as it is against the law to open a prisoner's legal correspondence unless the governor has reasonable cause to believe that it contains an illicit enclosure (Her Majesty's Government, 1999).

Drug seizures within prisons

In response to a written question in the House of Commons, in March 2017 the Prisons Minister reported the total number of drug seizures in prisons between October 2015 and December 2016 (see Table 5.3). There were 10,474 seizures in prisons in England and Wales in 2016, with a total weight of 225 kg. Of the seizures where the quantity of drugs seized was known, almost half (46%; n=3,577) were of amounts less than 2 g. There were 515 seizures of quantities over 100 g in 2016.

65 See: https://www.gov.uk/government/news/new-squad-formed-to-tackle-drone-threat-to-prisons

Table 5.3: Incidents of drugs found in prisons in England and Wales, by weight, October 2015 to December 2016

	2015 (Oct to Dec)		2016 (full year)	
	No. of seizures	% (valid)	No. of seizures	% (valid)
Less than 2 g	979	47.6%	3,577	45.7%
2 to 10 g	650	31.6%	2,526	32.3%
11 to 50 g	228	11.1%	865	11.0%
51 to 100 g	93	4.5%	348	4.4%
101 to 200 g	60	2.9%	256	3.3%
201 to 300 g	11	0.5%	90	1.1%
301 to 400 g	10	0.5%	48	0.6%
401 to 500 g	13	0.6%	45	0.6%
501 to 1,000 g	8	0.4%	50	0.6%
Over 1,000 g	3	0.1%	26	0.3%
Sub-total	2,055	100.0%	7,831	100.0%
Unknown	533		2,643	
Total	2,588		10,474	

Source: http://www.parliament.uk/business/publications/written-questions-answers-statements/written-question/Commons/2017-02-17/64326/

Alongside urine analysis, drug seizures made in each of the ten prisons participating in the *North West 'Though the Gate Substance Misuse Services' Drug Testing Project* were reported in June 2017 (National Offender Management Service & LGC, 2017). Of the 1,088 seizures made across the ten establishments, 426 (39%) contained SCRAs (see Table 5.4). 5F-AKB48 was the most commonly seized SCRA, detected in 317 seizures (29% of all seizures; 74% of SCRA seizures). 5F-PB-22 was detected in 258 seizures (24% of all seizures; 61% of SCRA seizures). Traditional drugs of misuse were found in 283 seizures (26% of all seizures), most commonly cannabis, which was found in 150 seizures (14% of all seizures). Steroids were detected in 151 seizures (14% of all seizures), and other substances were present in 142 seizures (13%), including 86 buprenorphine seizures (eight per cent of all seizures).

Table 5.4: Seizures reported by the ten prisons participating in the North West 'Through the Gate Substance Misuse Services' Drug Testing Project

	No. of seizures	% of all seizures
SCRAs	426	39%
5F-AKB48	317	29%
5F-PB-22	258	24%
Traditional drugs	283	26%
Cannabis	150	14%
Cocaine	19	1.7%
Heroin	14	1.3%
Steroids	151	14%
Others	142	13%
Buprenorphine	86	7.9%
Negatives	86	7.9%
Total	1,088	100%

Source: (National Offender Management Service & LGC, 2017)

Research conducted within a category B local prison in England suggested that the types of drugs seized between 2005 and 2015 altered dramatically (Ralphs et al., 2016). In the first three months of 2015, 973 g of SCRAs were seized, with 15 g of cannabis and three grams of heroin seized in the same period. The mass of SCRAs seized in just this quarter of 2015 outweighed the total recovered in the same prison in the whole of 2014 (969 g). Comparison to data from 2005 demonstrated the marked decreases in the amounts of cannabis and heroin seized: in one month in 2005, seizures of cannabis and heroin totalled two kilograms and 60 g respectively.

In November 2017 the SPS responded to a Freedom of Information request detailing the number of drug seizures in Scottish prisons every year from 2010/11 to 2017/18 (figures given for 2017/18 were up to and including 8 November 2017) (see Table 5.5). As part of the response, the SPS also gave the quantity of seizures of heroin, cocaine, cannabis, amphetamine and miscellaneous tablets from within Scottish prisons; this represented data from presumptive testing which is undertaken before seizures are handed over to the police (see Table 5.6).

*Table 5.5: Number of drug seizures made in Scottish prisons in 2010/11 to 2017/18**

	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18*
No. seizures	2,062	1,755	1,702	1,943	1,784	2,078	2,216	1,666

*Data up to and including 8 November 2017

Source: http://www.sps.gov.uk/FreedomofInformation/FOI-5335.aspx

*Table 5.6: Quantity of drugs seized in Scottish prisons subjected to presumptive testing, 2010/11 to 2017/18**

	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18*
Amphetamine (g)	251.3	659.1	48.9	62.6	412.8	33.5	2.6	512.9
Cannabis (g)	2,645.3	3,513.4	2,985.1	2,669.7	1,778.5	3,913.0	322.6	2,685.6
Cocaine (g)	330.4	398.2	297.5	106.4	77.9	56.5	196.5	71.0
Heroin (g)	949.1	817.8	542.6	642.1	387.9	891.9	384.4	394.0
Misc. tablets (no.)	18,798	18,548	16,069	17,984	13,751	18,453	2,315	8,477

*Data up to and including 8 November 2017

Source: http://www.sps.gov.uk/FreedomofInformation/FOI-5335.aspx

Drugs found in prisoners' possession

In response to a written question in the House of Commons, in December 2017 the Prisons Minister reported that there had been 13,607 incidents where a prisoner had been found in possession of drugs in England and Wales between October 2015 and October 2017.[66]

Drug administration

The SPS 2016/17 annual report showed that 1,116 male and 48 female prisoners were disciplined for "administering, or allowing to be administered, a controlled drug to oneself" during that year. This was an overall increase from 2015/16 when the total was 1,164. Rates per 1,000 prisoners increased for males, but decreased for females (see Table 5.7). Overall rates per 1,000 prisoners have increased every year since 2012/13 (Scottish Prison Service, 2017b).

Table 5.7: Number and rate per 1,000 prisoners of incidents where an inmate was disciplined for administering, or allowing to be administered, a controlled drug to oneself in Scottish prisons, 2012/13 to 2016/17

		2012/13	2013/14	2014/15	2015/16	2016/17
Male	Number of incidents	509	790	901	1,031	1,116
	Rate per 1,000 prisoners	*67.4*	*106.5*	*123.3*	*141.8*	*155.3*
Female	Number of incidents	125	79	102	102	48
	Rate per 1,000 prisoners	*273.5*	*183.3*	*240.0*	*252.5*	*131.1*
Total	Number of incidents	634	869	1,003	1,133	1,164
	Rate per 1,000 prisoners	*79.1*	*110.7*	*129.7*	*147.6*	*154.1*

Source: (Scottish Prison Service, 2013, 2014, 2015b, 2016, 2017b)

5.4 Drug-related problems among prisoners

5.4.1 Violence and intimidation

Anecdotal evidence suggests that the prevalence of SCRA use in prisons is linked to a number of negative outcomes, including an increase in disturbed and disruptive behaviour by prisoners, increasing debt, and heightened levels of intimidation and violence towards both staff and prisoners (National Offender Management Service, 2015). Until May 2016, a large number of

66 See: http://www.parliament.uk/business/publications/written-questions-answers-statements/written-question/Commons/2017-12-05/117496/

SCRAs were not controlled in the UK; therefore, due to their relatively low price in the community and the lack of comprehensive testing capable of detecting the use of these substances, SCRAs have been smuggled into prisons to be sold at a high profit, reportedly for up to 30 times their price outside of prison (Ralphs et al., 2016; User Voice, 2016).

In their report *Changing Patterns of Substance Misuse in Prisons and Service Responses*, HMIP described how debts accrued by prisoners could accumulate quickly, and be passed on to others (for example if a prisoner in debt left the prison, their debt can be passed on to friends or former cell mates) (Her Majesty's Inspectorate of Prisons, 2015). Prisoners who were prescribed medication may sell this to pay off their debts, or to be able to buy other drugs; and others became involved in the selling or transporting of drugs. Debt accrued as a result of SCRA use has been associated with violence and intimidation. Prisoners in debt may be used as 'spice pigs', whereby they are forced by dealers to test new SCRA products to ascertain what quantities are safe and the effects caused by the product (Her Majesty's Inspectorate of Prisons, 2015; User Voice, 2016).

Over the past three years, there has been an increase in the rate of assault incidents reported in prisons in England and Wales, and SCRA use is a possible contributing factor to this rise. In its bulletin on the Safety in Custody Statistics, the MOJ reported that in the 12 months to September 2017, compared to the same period in the previous year, there was a 9.4% increase in the number of prisoner on prisoner assault incidents (rate per 1,000 prisoners; 238/1,000 versus 218/1,000), and a 22% increase in assaults on staff (rate per 1,000 prisoners; 91/1,000 versus 75/1,000). The assault rate on staff has more than doubled since September 2014. Serious prisoner on prisoner assaults increased from 31 per 1,000 prisoners in the 12 months to September 2016 to 35 per 1,000 in the 12 months to September 2017 (a 13% increase). The number of serious assaults on staff rose from 762 to 787 (a three per cent increase), although the September 2017 figure represented a 31% increase on the number recorded in the 12 months to September 2015 (n=602) (Ministry of Justice, 2018). The total number of serious assaults in prisons in England and Wales seen in the 12 months to September 2017 is around two and a half times the number seen in the equivalent period in 2012/13. However, this increase has coincided with a reduction in prison staff, with the number of public sector prison officers[67] falling from 24,831 in March 2010 to 21,505 in March 2013, and to 17,888 in December 2016 (Ministry of Justice, 2017b). It is therefore also possible that changes to staffing numbers may have had an impact on violence levels within prisons.

Prisons in Scotland have also seen an increase in the number of assaults since 2012/13, although not to the same extent as those in England and Wales. In 2016/17 there were 2,329 minor assaults/assaults resulting in no injury on prisoners and staff, compared to 2,173 in 2015/16; this figure has increased from 1,921 in 2012/13. There were also 79 serious assaults (both on prisoners and on staff) in 2016/17, a slight decrease from 83 in 2015/16 (Scottish Prison Service, 2013, 2016, 2017b).

5.4.2 Self-harm and deaths in prison

As well as an increase in assaults, SCRA use is also thought to have contributed to an increase in the number of self-harm incidents occurring in prisons in England and Wales. The MOJ reported that in the 12 months to September 2017, compared to the same time period in 2015/16, there had been a 12% increase in the number of self-harm incidents (rate per 1,000 prisoners; 501 versus 448). The number of prisoners who self-harmed in the 12 months to September 2016 was 11,248 (131 prisoners per 1,000). This represented a three per cent increase on the rate of self-harmers per 1,000 prisoners on the previous year, and a 49% increase on the equivalent

67 Operational staff at bands 3 to 5, including prison officers, supervising officers and custodial managers

figure from the 12 months to September 2014 (88 prisoners per 1,000) (Ministry of Justice, 2018).

The number of deaths in prisons in England and Wales reported in the year ending in December increased every year from 192 deaths in 2012 to 354 deaths in 2016, an 84% increase. However, in 2017, the number of deaths fell to 295, a 17% decrease from 2016. Of the 295 deaths to December 2017, 70 were self-inflicted, down from 122 the previous year. The rate of all deaths per 1,000 prisoners in the 12 months to December 2017 was 3.4, an increase of 55% on the rate seen in the year to December 2012 (2.2 per 1,000) (Ministry of Justice, 2018).

In July 2017, in a speech to the All-Party Parliamentary Group on Penal Affairs, the Prisons and Probation Ombudsman (PPO) reported that there had been 79 deaths that had occurred in prisons in England and Wales between June 2013 and September 2016 where the deceased was known or strongly suspected to have taken NPS before death, or where their NPS use was a key issue during their time in prison. Of the 79 deaths, 56 were self-inflicted (Prisons and Probation Ombudsman, 2017b).

In a previous speech in November 2016 (Prisons and Probation Ombudsman, 2016b), the PPO outlined five risk factors that played important roles in NPS deaths in prison:

- mental health risks – the majority of NPS-related deaths were self-inflicted, with psychotic episodes believed to be responsible for some, and extreme and unpredictable behaviour also found
- physical health risks – NPS may exacerbate the effects of underlying medical problems, and nine deaths were due to natural causes in prisoners who used NPS
- drug toxicity – deaths have been attributed to the toxicological effects of NPS or NPS in combination with other drugs
- debt and bullying – prisoners in debt to dealers may be at increased risk of self-harm or suicide due to the bullying and violence they experience
- behavioural problems – prisoners displaying aggressive or violent behaviour caused by their NPS use may not be identified to be using these substances, therefore opportunities for substance misuse and healthcare teams to intervene may be missed

The PPO also outlined five areas of learning for prison staff to help to decrease the adverse effects that NPS are having among prisoners: reducing the supply of NPS; increasing staff awareness of NPS-related problems; addressing bullying and debt problems robustly; treatment services addressing NPS use and offering appropriate monitoring and treatment; and reducing demand for NPS among prisoners.

5.4.3 Blood-borne viruses

Prisoners may be at increased risk of spreading BBVs compared to injecting drug users in the community, as they may be more likely to share injecting equipment as well as other items that could transmit BBVs such as toothbrushes and tattoo equipment. In the most recent *Prisoner Survey* in Scotland, six per cent of prisoners said that they had ever injected drugs in prison, with two per cent saying that they had done so in the past month. However, of those injecting in the past month, 82% had shared their injecting equipment (Scottish Prison Service, 2015a). In comparison, of those that had injected in the past six months taking part in the *Needle Exchange Surveillance Initiative* survey in Scotland in 2015/16, six per cent had used a needle/syringe that had previously been used by someone else in the past six months, and 20% had

used other injecting equipment such as filters or spoons that had previously been used by someone else in the past six months (Health Protection Scotland, 2017b).

The SPS commissioned a study into the prevalence and incidence of hepatitis C among a sample of 5,076 prisoners in Scotland in 2009 (Scottish Prison Service, 2012). The hepatitis C virus (HCV) antibody prevalence among all prisoners who participated in the study was 19%; however, among injecting drug users (IDU) the prevalence was 53%. HCV antibody prevalence was higher in female IDU (65% versus 52% in male IDU) and older IDU (68% in those aged 40 years and over versus 14% in those aged under 20). Additionally, female IDU in prison had a higher HCV positive rate than those in the community (65% versus 54%, respectively). The estimated hepatitis C incidence rate was less than one per cent (or one per 100 person years) among all prisoners, less than three per cent among prisoners with an injecting history, and five to seven per cent among prisoners who had ever injected in prison.

Information on the overall prevalence of BBVs within prisons in England is not collected routinely. In 1997/98 the then Public Health Laboratory Service estimated that the prevalence of previous exposure to hepatitis C within English prisons was 11% among female prisoners, nine per cent among male prisoners, and 0.6% among young male offenders.[68] Opt-out testing for BBVs on reception to prison has now been introduced across England and Wales; see section 5.5.4 for further information.

BBV testing programmes and access to treatment are available in each prison in Northern Ireland. In 2016, of the 3,893 individuals committed to a prison, 10% (n=406) were tested for a BBV, and two per cent (n=92) of those in custody were known to have a BBV (personal communication – Northern Ireland Prison Service).

5.4.4 Drug-related deaths on release from prison

A number of studies have established that offenders newly released from prison are at increased risk of drug-related death than individuals in the general population. Farrell and Marsden showed that in England and Wales male prisoners were 29 times more likely to die in the first two weeks following release than members of the general population, and female prisoners were 69 times more likely to die in this period than the general population. The prime cause identified in this study was overdose of heroin or other opioids (Farrell & Marsden, 2008). Additionally, a meta-analysis demonstrated that for prisoners in England, Wales and Scotland, the relative risk of drug-related death within the first two weeks after release was 7.5 times that of dying within weeks three to 12 after release, and 9.0 times the risk of drug-related death in weeks five to 12. While lower than the risk seen in the first two weeks, the risk of drug-related death was still elevated in the third and fourth weeks after release (Merrall et al., 2010). Possible reasons for this increase include a reduction in individuals' tolerance to opioids occurring while they are in prison, particularly if they have undergone detoxification, and variability in the purity of drugs such as heroin, meaning that users may be unaware if an increase in strength has occurred while they were imprisoned. As part of the response to this increased risk of death, national naloxone programmes in Scotland, Wales and Northern Ireland distribute the opioid antidote naloxone to offenders at the point of release from prison (see section 5.5.3).

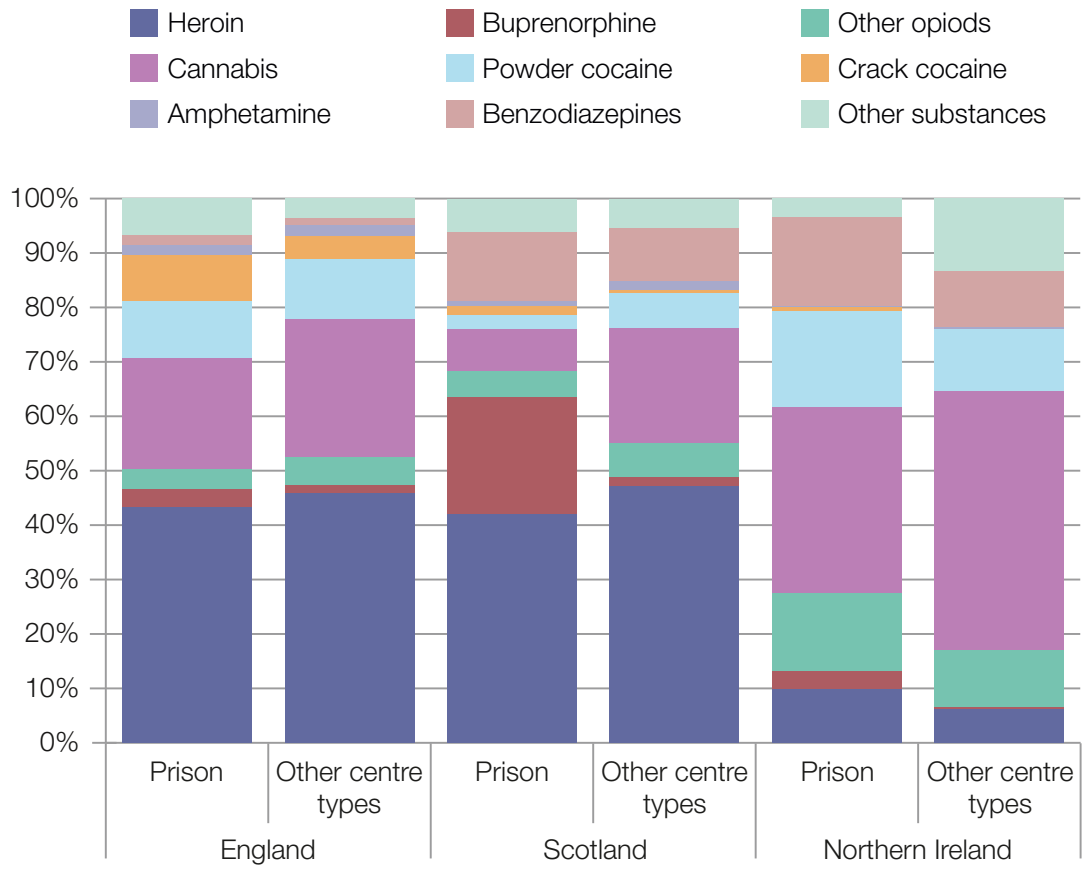
68 See: https://publications.parliament.uk/pa/cm200506/cmhansrd/vo051201/text/51201w31.htm

5.5 Drug-related health responses

5.5.1 Clients receiving treatment in prison

In 2015, data from the National Drug Treatment Monitoring System (NDTMS) became available for all clients receiving treatment in prison in England. Public Health England (PHE) published its first annual statistics report on clients receiving treatment in prisons in 2017 (covering 2015/16), and primary substance breakdown data for those presenting to treatment during 2016 is available for prison treatment clients in England, Scotland and Northern Ireland.

Figure 5.1: Percentage of clients presenting to treatment in prisons and all other treatment centre types in England, Scotland and Northern Ireland in 2016, by primary drug (where recorded)



Source: Accompanying table 3.8

England

In 2016, 27,575 clients presented to treatment units in prison; this represented more than one-quarter (28%) of all clients presenting to treatment in England. The proportion presenting for opioid use was slightly lower in prison than in the community (50% in prison; 52% in the community), with a smaller proportion of primary heroin clients in prison (43%) than in the community (46%) (see Figure 5.1). Cannabis was the second most common reason for presentation in prison, with 20% of clients reporting primary use of this drug (compared to 25% in the community). Double the proportion of clients reported primary use of crack cocaine in prison than in the community (8.5% and 4.3%, respectively).

The primary drug breakdown does not list SCRAs separately and clients citing primary SCRA use are therefore included in the 'other substances' category. More than five per cent (5.4%) of

clients in prison presented citing 'other substances' as their primary drug, compared to 1.4% in the community; it is likely that many of these clients presented with SCRA use (see below). More comprehensive data from individuals receiving drug treatment in secure settings in England was published by PHE in January 2017, which covered all those in treatment as well as those presenting during the year (Public Health England, 2017k). Seven per cent (n=3,609) of clients reported an NPS as a problematic substance, with 2,163 (4.2% of all clients) reporting use of a cannabinoid-type NPS. This was more than one-and-a-half times the number of clients in the community reporting use of a cannabinoid-type NPS (n=1,277) in England in 2015/16, despite the overall number of clients receiving treatment in the community being several times higher than in prison (Public Health England, 2016a).

Scotland

Scottish data originating within prisons was identifiable for the first time in 2016;[69] during this year 1,778 clients were recorded as presenting to treatment within prison in Scotland. Of the 865 clients for whom their primary drug was known, the majority reported an opioid as their primary substance (68% for prison clients; 55% for those presenting to other centre types). Most of these clients presented with heroin as their primary substance (62% of opioid clients; 42% of all prison clients) (see Figure 5.1). Buprenorphine was the second most common primary substance, with 22% of all prison clients reporting primary buprenorphine use, compared to 1.7% of clients from other treatment types. This reflects APT results from Scotland, which found that buprenorphine was the most commonly detected substance in samples from prisoners at liberation in 2016/17 (see Table 5.2). Less than ten per cent (7.9%) of those presenting to treatment in Scottish prisons reported primary cannabis use, compared to 21% of clients from other treatment centre types. As with the English data, the proportions of prison clients presenting for powder cocaine (2.4%) and stimulants other than cocaine (1.3%) were lower than in the community (6.4% and 2.5%, respectively), whereas the proportions presenting in prison for primary crack cocaine (1.7%) or benzodiazepine (12.6%) use were higher (0.5% and 9.7%, respectively) (see accompanying table 3.8).

Northern Ireland

In 2016, 533 individuals presented to drug treatment in prisons in Northern Ireland, a 5% reduction in the number of clients from 2015 (n=564). This represented 22% of all clients presenting to treatment in Northern Ireland in 2016. The most common primary drug on presentation was cannabis, which was reported by 34% of clients (see Figure 5.1), an increase from 2015 (26%). Just over one-quarter (27%) of clients reported primary use of opioids. Primary use of 'other opioids' was more frequently reported than each of the individual opioids recorded (heroin, methadone, buprenorphine and fentanyl) combined. This category (which includes codeine, dihydrocodeine and tramadol) was reported by 14% of all prisoners, compared with 9.8% of prisoners who reported primary use of heroin. Primary benzodiazepine use was reported by 16% of prisoners, a decrease from 23% in 2015, but similar to the proportion of prisoners reporting primary use of these substances in 2014 (15%). Just under one-fifth (18%; n=98) of prisoners presented with primary use of cocaine. The percentage of treatment presentations for primary cannabis use was lower than that for those presenting to treatment in the community (47%), whereas the proportions of clients presenting due to opioid and heroin use in prison were higher than in the community (community figures of 6.1% for heroin and 17% for opioids). Primary cocaine users accounted for a greater proportion of presentations in prison than in the community (18% versus 11%); however, stimulants other than cocaine were much more commonly reported in community treatment centres than in prison (7.2% and 1.5% respectively) (see accompanying table 3.8).

69 All other Scottish TDI data for 2016 was classified under the 'not known/missing' header for treatment centre type

5.5.2 Opioid substitution treatment

England

The expansion of OST provision in England was supported by the publication of guidance from the then Department of Health (DH) and the MOJ on continuity of care going between the community and prisons (Department of Health & Ministry of Justice, 2011), and guidelines for assessment and prescribing were provided by the recently updated *Drug Misuse and Dependence: UK guidelines on clinical management* (Department of Health, 2017a). Opioid-dependent individuals entering prison are initially stabilised on agonist therapy, and those currently receiving a community OST prescription may continue to receive this prescription after entry if a number of criteria are met. The new clinical guidelines state that any plan for the reduction and cessation of OST should be based on the clinical judgement of the prescriber, in collaboration with the prisoner and the wider healthcare team.

Data from PHE's report on the number of clients in treatment in English prisons showed that of the 51,703 individuals receiving treatment for drug use in 2015/16, 22,368 received some form of pharmacological intervention for opioid use (Public Health England, 2017k). The medication prescribed (for example methadone, buprenorphine, naltrexone) was not specified in this dataset.

Scotland

In 2015, 20% of respondents to the Scottish *Prisoner Survey* reported that they were receiving methadone in prison: 57% of these prisoners were receiving a maintenance dose; 22% were receiving a stabilising dose; and 21% were receiving a reducing dose (Scottish Prison Service, 2015a).

Northern Ireland

OST is available in all three Northern Irish prisons, but induction on to OST is only available in HMP Maghaberry. Between 1 April 2015 and 31 March 2016, 30 prisoners in Northern Ireland received OST (Health and Social Care Board & Public Health Agency, 2017b). Although data is unavailable on the OST medication prescribed in prisons elsewhere in the UK, a greater proportion of prisoners are prescribed buprenorphine in Northern Ireland than is thought to be the case in the other countries: 27% of prisoners on OST were prescribed this treatment, with 42% prescribed methadone, and 31% unknown.

5.5.3 Take-home naloxone

As discussed in section 5.4.4, prisoners are at a much greater risk of drug-related, and particularly opioid-related, death in the immediate period after release from prison than the general population. National THN programmes have been established in Scotland, Wales and Northern Ireland, and as part of these programmes prisoners who are at risk of opioid overdose when back in the community are issued with THN kits at the point of release. Data on the number of kits distributed to prisoners at release is routinely reported by Scotland and Wales. The availability of THN to prisoners in England has so far been limited: naloxone has been made available to some extent in some prisons, and its distribution is not required under current treatment guidelines.

Wales

Of the six male-only prisons in Wales, three currently provide THN to prisoners identified as being at risk of overdose on release. During 2016/17, work has been carried out to establish supply of THN to the remaining prisons, and distribution of THN was successfully implemented

within HMP Eastwood Park in Gloucestershire (serving as Wales' closest female prison) and Welsh police custody suites. Data from the Harm Reduction Database showed that 14% (n=208) of all new unique individuals issued with THN in 2016/17 were issued on release from prison or police custody (Public Health Wales, 2017). In total, 655 kits were supplied from Welsh prison settings in 2016/17, a 98% increase from 2015/16 (n=330). When compared to national provision, prison supply acts as one of the highest distributors of THN. The issue of THN to new individuals represented 32% of all prison-based supplies. Supply to new clients within the male prison estate in 2016/17 declined by 0.7% when compared to the previous year, from 146 to 145 individuals.

Scotland

The independent National Naloxone Advisory Group (NNAG) for Scotland was the body that engaged with the Scottish government to manage central funding of naloxone kits, allowing for continued service provision. The work of the NNAG ceased on 31 March 2016, when responsibility for kit reimbursement passed to NHS boards; however, the Harms Reduction sub-group of the Scottish government will monitor naloxone provision. The SPS and NHS health boards work in partnership to enable prisoners to undertake naloxone training while in custody and receive a naloxone kit on release.

There were 720 THN kits issued by NHS staff working in prisons in Scotland in 2016/17 (Information Services Division, 2017d). NHS Highland is currently undertaking a pilot whereby individuals are issued with intranasal naloxone kits outwith the Scottish national naloxone programme; 20 of the 720 kits were intranasal THN kits distributed from HMP Inverness. Of the 700 injectable kits issued, 669 were to persons at risk of opioid overdose upon release and 31 were to friends and family of those at risk. Overall, this represented a 25% decrease on the number issued in 2015/16 (932 injectable kits, and 27 intranasal kits). Since 2011/12, 5,043 injectable THN kits and 84 intranasal naloxone kits have been issued from a Scottish prison setting in total.

Of the 645 kits issued to individuals at risk of opioid overdose where data was available for the individual, 76% (n=492) were issued to males and 24% (n=153) were issued to females. As females comprise five per cent of the Scottish prison population (see section 5.2.2), this suggests a relatively higher uptake of THN among female prisoners than male prisoners. However, this may also be due to the high level of engagement with the national naloxone programme at HMP Cornton Vale, Scotland's only all-female prison. Over the course of the programme there has been an increase in the proportion of older recipients, with the proportion of THN kits going to those in the 25-34 age bracket falling from 53% in 2011/12 to 39% in 2016/17, and the proportion going to those in the 35-44 age group increasing from 23% in 2011/12 to 40% in 2016/17. However, recipients of THN in prisons were comparatively younger than those receiving kits in the community.

There has been a steady decline in the percentage of all opioid-related deaths occurring within four weeks of prison release, from the 2006-2010 baseline indicator of 9.8% to 3.1% in 2014 (Information Services Division, 2015b). This percentage increased in 2015 to 4.7%; this was the same proportion that was seen in 2013, and is still significantly lower than the baseline indicator value, although the authors noted the figures should be treated with caution given the low numbers involved (n=23 in 2015) (Information Services Division, 2016b). Performance against the baseline indicator will continue to be monitored to ensure that the percentage in the post-naloxone period is estimated with sufficient precision.

In 2015 the SPS conducted a pilot in HMP Inverness which tested the effectiveness of a training programme in naloxone administration to operational prison staff, which trained them to administer intra-muscular naloxone to prisoners in emergency 'first on the scene' situations.

The SPS is now reviewing the options available to develop future training for front line staff responding to opioid overdoses (Scottish Prison Service, 2016).

Northern Ireland

The pilot of a THN initiative is currently being undertaken by a partnership between the Public Health Agency and the Health and Social Care Trusts; community addiction teams and NIPS began to give out THN kits in July 2012. THN training is jointly provided by Alcohol and Drugs: Empowering People through Therapy (AD:EPT) and the South Eastern Health and Social Care Trust (SEHSCT) clinical addiction team to anyone at risk of an overdose; in 2016, 55 people were trained in THN by AD:EPT.

5.5.4 Blood-borne virus testing

England

One of the developmental priorities of the *National Partnership Agreement for the Co-Commissioning and Delivery of Healthcare in Prisons in England* between NHS England, PHE and the National Offender Management Service (NOMS) (see section 5.7.1) was to improve the detection, surveillance and management of infectious diseases in prisons (NHS England, Public Health England, & National Offender Management Service, 2015). In April 2014 a new opt-out testing programme for BBVs was introduced in prisons across England. Preliminary data from the health and justice indicators of performance (HJIPs) (see section 5.6.2) indicated that of the 214,606 new receptions to the 112 prisons providing data in 2016/17, 37,474 (17.5%) were tested for HIV. From these tests, 942 HIV infections were reported, giving a HIV prevalence of 2.5%. It is not known how many of these diagnoses were new (Public Health England, 2017h). The most recent data shows that between 1 April and 30 June 2017, 6,563 HBV tests, 8,797 HCV tests and 10,574 HIV tests were carried out on new receptions to prison (representing 19%, 16% and 22% of all new receptions and transfers, respectively, excluding previously confirmed cases) (Public Health England, 2017b). The numbers of individuals testing positive were: 133 for HBV (2.0%); 1,590 for HCV (18%); and 197 for HIV (1.9%).

Wales

BBV testing programmes and access to treatment are available in each prison in Wales. In 2015, 13% of receptions to Welsh prisons were tested for BBV (personal communication – Public Health Wales). This was a small decrease from 14% of prison receptions undergoing testing in 2014.

Scotland

The Scottish government are working with NHS boards and the SPS to introduce opt-out testing for HBV, HCV and HIV for all new prisoners in Scotland during their induction period (Scottish Government, 2015b). As of November 2016, opt-out testing for these three viruses was available for new prisoners at eight prisons (out of the 15 in Scotland), with an additional three prisons conducting opt-out testing for HCV and HIV.[70]

In the *Prisoner Survey 2015*, 46% of respondents reported that they had been tested for hepatitis C while in prison (Scottish Prison Service, 2015a).

70 See: http://www.parliament.scot/parliamentarybusiness/28877.aspx?SearchType=Advance&ReferenceNumbers=S5W-04546&ResultsPerPage=10

5.6 Guidelines and quality assurance of drug-related prison health responses

5.6.1 United Kingdom

In July 2017, the *Drug Misuse and Dependence: UK Guidelines on Clinical Management* were published (Department of Health, 2017a) (see section 4.7.1). These guidelines are an update of those published in 2007 (Department of Health England and the devolved administrations, 2007), and contain a substantially expanded section on the provision of treatment within criminal justice settings, especially prisons, which replaces what was separately-published clinical guidance for prison drug treatment. The guidelines cover screening and assessment upon entry into prison; the management of opioid dependence and withdrawal symptoms associated with certain substances within the first few days of imprisonment; continued maintenance prescribing and detoxification within prison; and the transition from treatment within the prison setting to the community. Other issues such as management of opioid overdose, NPS use, pain management and image and performance enhancing drug use are also covered.

5.6.2 England

There are a number of indicators on the Public Health Outcomes Framework (see section 2.3.2) related to people in contact with the CJS. Until April 2016, one such indicator was the proportion of people assessed for substance dependence issues when entering prison who then require structured treatment and who had not previously received community treatment. This measure was designed to give local authorities (LAs) an indication of the scale of unmet treatment need in the community; in 2012/13 the average proportion across England was 47% (Public Health England, 2015d).

Following a consultation in 2015, this indicator was amended in May 2016 to report the proportion of adults with substance misuse treatment needs who successfully engaged in community-based structured treatment following release from prison (Department of Health, 2016). Prisoners with substance misuse treatment needs are at increased risk immediately following their release from prison; this indicator therefore measures their engagement with treatment services during this important period. In 2016/17 the average proportion across England was 30%.[71]

A set of HJIPs developed by NHS England, PHE and NOMS to replace the previous prison health performance and quality indicators were introduced in 2014 (NHS England, 2014). These indicators are largely quantitative measures and include specific measures for drugs and alcohol. NHS England area teams work with their commissioned providers to collect the HJIPs with the aim of:

- supporting effective commissioning of healthcare services in places of detention
- enabling national and local monitoring of the quality and performance of healthcare in the secure estate
- providing a tool for providers to review their performance and identify areas that need improvement
- providing data for local health needs assessments

71 See: http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000042

- providing assurance to commissioners and partners that healthcare delivery in prisons is fit for purpose
- providing information for the Care Quality Commission and HMIP to support their inspection work

In May 2015 the Royal College of Psychiatrists' Centre for Quality Improvement established a Quality Network for Prison Mental Health Services, with the aim of promoting quality improvement in the field of prison mental health. This field is becoming increasingly important with regard to substance misuse, with the increase in prevalence of SCRAs in prison and the mental health issues that have been associated with their use (see section 5.4.2). The network published its first edition of standards for services in June 2015, and the third edition of the standards was published in October 2017 (Royal College of Psychiatrists Centre for Quality Improvement, 2017b). Standards include requiring written policies in place for liaison and joint working with substance misuse services and primary care in cases of co-morbidity, and a joint working policy on the control and management of substance misuse and illicit substances. Thirty-eight mental health services from 40 prisons across the UK and Ireland participated in the first full year of the network following the pilot year. Member services are reviewed against the specialist standards for prison mental health services, the results of which were published in the network's annual report in October 2017 (Royal College of Psychiatrists Centre for Quality Improvement, 2017a).

5.6.3 Scotland

In February 2016 the National Prisoner Healthcare Network published joint guidance for quality service delivery of drugs, alcohol and tobacco health services in Scottish prisons (NHS Scotland & Scottish Prison Service, 2016). This report discussed drug prevalence in Scottish prisons and reviewed current service delivery, including drug treatment services. The report also discussed current best practice in substance use interventions, and made a number of recommendations covering: data capture and reporting; use of national standards (for example adhering to relevant local delivery plan standards) and the development of service quality indicators; provision of purposeful activity; capacity of treatment services; and the use of service user views in planning and delivery.

5.6.4 Wales

Across the public sector prison estate in Wales, standards of treatment provision will be matched against those set out above. In addition, the practice standards issued by the Royal College of Psychiatrists in relation to mental health services for prisoners will also be adopted.

5.7 Co-ordination of drug-related prison health responses

5.7.1 England and Wales

In England, the Department of Health and Social Care (DHSC) is responsible for determining the policy on substance misuse treatment and suitable approaches, including the balance between clinical treatment and psychosocial interventions. Substance misuse treatment services in custody are commissioned and funded by NHS England.

HMPPS (formerly NOMS) and NHS England have a responsibility to enable and support the efficient delivery of provision. A tripartite agreement on co-commissioning and delivery of healthcare in English prisons between NHS England, HMPPS and PHE (NHS England et al.,

2015), sets out respective roles, shared principles and development priorities as well as objectives to work together and address any issues arising from changes to the delivery environment. The agreement is overseen by the Prison Healthcare Board (England). HMPPS is responsible for providing supervision to the highest risk offenders in the community, while 21 CRCs supervise lower to medium risk offenders.

In Wales, health and delivery of its services within public sector prisons are the responsibility of the Welsh government, with responsibility for service provision devolved to local health boards. The exception is non-clinical substance misuse services for sentenced offenders, for which HMPPS has responsibility.

5.7.2 Scotland

In Scotland, the NHS has been responsible for the provision of healthcare services in prisons since November 2011. The 15 prisons in Scotland are located within nine of the 14 NHS boards in Scotland, each of which has responsibility for providing substance misuse services to prisoners within these areas. NHS boards provide a range of health and substance misuse services through primary and secondary care practitioners to those in prison.

A national health improvement framework, *Better Health, Better Lives*, is supporting the delivery of action to improve health and wellbeing in prisons (Brutus et al., 2012). The framework provides recommendations consistent with a 'whole prison' approach to health improvement, and is built around health promotion pillars which include illicit drugs, tobacco and alcohol. It supports action planning focusing on policy development, the creation of healthy working, living and learning environments and prevention, health education and other health promotion initiatives.

The *Better Health, Better Lives* framework supports an asset-based approach recognising the positive potential of prisoners, staff and the internal and external prison environment to support improved outcomes in health and wellbeing. The aim is to deliver innovative action that meets consistent standards, includes meaningful prisoner involvement, is underpinned by workforce development and links into services and support out in the community.

The national multi-agency Prison Health and Wellbeing Group concluded in 2017, and health improvement standards within the prison setting will be implemented later this year.

The Health Improvement Framework for Offenders in the Community is now being delivered by the National Health Improvement Agency, NHS Health Scotland, as part of their work supporting community justice. It will provide useful guidance to partners in the new model for community justice which has been designed to deliver a community-based local solution to achieving improved outcomes for community justice, reducing re-offending, and supporting desistance.

5.7.3 Northern Ireland

The provision of substance misuse services within Northern Ireland's prisons has undergone significant change in recent years. The transfer of responsibility for prison healthcare services to the SEHSCT, and recommendations from a number of independent reviews, surveys and inspections, have influenced and reflected on a period of continued transition and change.

The provision of substance misuse services has seen progress regarding the implementation of a joint Prison Service and Trust Management of Substance Misuse in Custody strategy, which has now been signed off. Each of the prisons within Northern Ireland provides a range of treatment interventions through primary care, secondary care and specialist addiction services.

The new SEHSCT Strategic Framework (July 2015) is currently in draft form. It aims to provide a template to ensure that substance misuse issues are recognised and that the challenges arising from a number of inspection reports, including joint Criminal Justice Inspectorate Northern Ireland / HM Chief Inspector and Regulation and Quality Improvement Authority inspections, and more recently, the publication of the *Safety of Prisoners held by the Northern Ireland Prison Service* (Criminal Justice Inspection Northern Ireland, 2014) report, are addressed. This can only be achieved through a multi-disciplinary, collaborative, partnership approach, not only involving staff from SEHSCT, AD:EPT and NIPS, but also a significant range of other providers, including support from community and voluntary sectors organisations, for example, Alcoholics Anonymous and Narcotics Anonymous.

5.8 Drug interventions in the broader criminal justice system

Rehabilitative and treatment opportunities are made available to those who need them at all stages of the CJS (police station, court, community sentence or custody) on a voluntary basis and as part of a court-mandated sentence or post-release licence.

5.8.1 England and Wales

Resettlement

Continuity of treatment following release from prison is recognised to be of great importance for individuals to achieve successful drug treatment outcomes. The MOJ has been working closely with partners in health to help extend the focus of substance misuse treatment and recovery services in prison to plan and operate through the gate into the community. Through the gate resettlement services have been introduced, meaning that every sentenced prisoner released from custody receives statutory supervision and rehabilitation in the community. Low and medium risk offenders (approximately two-thirds of offenders) are managed by community rehabilitation companies (CRCs), and high risk offenders are managed by the National Probation Service. CRCs and the National Probation Service are required to ensure that all sentence requirements or licence conditions/supervision requirements are delivered for the offenders they manage, which may include specific licence conditions such as attending drug appointments and drug testing (see below). Recent legislation means that all sentenced prisoners will be supervised for a minimum of 12 months post-release.

Drug rehabilitation requirement

A drug rehabilitation requirement (DRR) is available to courts as a sentencing option, under Section 209 of the *Criminal Justice Act 2003* (Her Majesty's Government, 2003). DRRs can be made as part of a community order or a suspended sentence order, and the treatment element is provided by local drug services. These provisions present local providers with the flexibility to tailor requirements to individual needs, changing patterns of substance misuse and moving towards a recovery-focused approach to treatment.

The supervision on licence of low-to-medium risk offenders is now managed by CRCs as part of the changes brought in by *Transforming Rehabilitation (*Ministry of Justice, 2013), with high risk offenders being supervised by the National Probation Service. In Wales, the director of HMPPS Wales is responsible for the planning and commissioning of drug treatment services for offenders on DRRs.

Out-of-court disposals

Drug interventions can be included in out-of-court disposals that are handed down by the police and the Crown Prosecution Service as an alternative to a formal charge. Where the offender has admitted guilt, the conditional caution can be used to require an offender to address their drug misuse, for example through attending a brief intervention, an appointment with a drug worker or undergoing treatment. If the conditions are not complied with, the offender could be charged for the original offence.

Drug testing on arrest

The primary methods of engaging drug misusing offenders with drug treatment services in England and Wales is through the interventions that formerly made up the Drug Interventions Programme (DIP), or through Liaison and Diversion (L&D) services (see below). Local drug treatment systems carry out drug assessments on arrestees and provide case management and support, and referrals to structured treatment where appropriate. The ability of police forces to undertake mandatory drug testing on arrest was implemented in 2006 for specified 'trigger offences' (that is, those most associated with opioid/cocaine use: shoplifting, robbery, theft) under the Home Office DIP. DIP ceased to be a national programme in April 2013; the decision as to whether to continue funding such interventions is now taken locally. The majority of LAs continue to report activity on interventions, including those resulting from drug testing on arrest, for individuals in contact with the CJS to PHE, and most police forces still run a drug intervention initiative based on drug testing on arrest. This suggests that the provision of such services has largely survived the transition to a locally led commissioning structure (personal communication – Home Office).

Liaison and Diversion

The L&D programme was created in 2010 in response to findings of the Bradley Report (Department of Health, 2009). L&D schemes are designed to identify, assess and screen offenders who have mental health, learning disability, substance misuse or other vulnerabilities, and refer them to an appropriate treatment or support service. Ten trial schemes were implemented from 1 April 2014 with a further 15 schemes instigated from 1 April 2015, taking coverage up to 50% of England. L&D services now cover 68% of the population of England and Wales, and it is anticipated that full coverage will occur in 2020/21.

5.8.2 Scotland

In Scotland, there are a number of interventions at different levels of the CJS, including diversion from prosecution to drug treatment/education, community payback orders with a drug treatment requirement, drug treatment and testing orders (DTTOs) for particularly high tariff offenders who are entrenched in their drug use, as well as services for prisoners post-release, including Throughcare Addiction Services. DTTOs provide offenders with access to treatment services with which they are required to comply, combined with regular progress reviews from the court. A less intensive version (DTTO II) has been developed for lower tariff offenders who are less entrenched in their drug use and offending. This scheme operates in Edinburgh and the Lothians, and currently accounts for about a quarter of the DTTOs in these areas. The Scottish government have supported widening the availability of DTTO IIs across Scotland in 2017 by working with the pilot site to develop guidance on how to develop and deliver a DTTO II service.

Throughcare Addiction Service

The Throughcare Addiction Service (TAS) forms part of the voluntary aftercare service. TAS is delivered by LA criminal justice social work who will work with the offender in the six week period prior to release from custody through the six week period post-release, offering an intensive motivational service to help the offender address their addiction and link them to appropriate services. Data shows that 633 individuals received assistance from the TAS on release from prison in 2014/15, just over half the number seen in 2013/14, and a decrease to 24% from 50% of all voluntary assistance cases (Scottish Government, 2016b).

The SPS provides a voluntary throughcare service for short term offenders with no statutory conditions placed on them. It aims to ensure that the transition from custody to the community is effectively managed in an approach that seeks to minimise the risk to the public and to support a safe transition for service users back into the community. It does so by working collaboratively with the service users, families, colleagues and partner agencies to develop an asset based individualised plan ("one person one plan"). Throughcare support officers support offenders on their journey into desistance by working with them to prepare for and successfully make the transition from custody into the community, acting as an advocate on their behalf with partner agencies and encouraging their motivation to change through sustained engagement with key services.

5.9 New developments

5.9.1 New psychoactive substances

England and Wales

The presence of SCRAs within prisons is now an established and significant problem in prisons in England, Wales and Scotland. One study carried out in ten prisons in north-west England found that SCRAs were the most commonly detected drug of misuse in pre-release urine samples taken from prisoners (excluding methadone, which may have been taken therapeutically) (National Offender Management Service & LGC, 2017) (see section 5.3.2).

In July 2017 the PPO reported that there had been 79 deaths in prisons between June 2013 and September 2016 associated with the use of NPS; this came after a report in November 2016 where the PPO reported on 64 deaths under similar circumstances between June 2013 and April 2016, and a speech in September 2016 where 58 deaths between June 2013 and January 2016 had been reported (Prisons and Probation Ombudsman, 2016a, 2016b, 2017b) (see section 5.4.2).

Prior to its closure, NOMS developed a new drug testing programme, the first in the world to routinely test for NPS through mandatory drug testing (MDT). This was implemented across the prison estate in September 2016.

The government published a white paper, *Prison Safety and Reform*, in November 2016 (Ministry of Justice, 2016b) (see section 2.3.3). In response to the problems caused by SCRA use in prisons (see section 5.4), the paper reported that 300 dogs had been trained to detect psychoactive substances in packages and on people, and that guidance had been provided to prison staff to support them in dealing with drug-related problems. It also set out the aim to recruit 2,500 additional prison officers in the public sector.

In December 2015 PHE published a toolkit designed to support prison custodial, healthcare and substance misuse staff. This provided information on the various categories of NPS, their prevalence within prisons, the effects seen after acute and chronic use of these substances, and

advice on the management of prisoners who have taken them (Public Health England, 2015c). The toolkit was supported by a training programme delivered by PHE and NOMS at 32 events attended by approximately 650 prison staff. In January 2017, PHE published a thematic analysis of the training programme, reflecting on some of the key themes and learning that emerged (Public Health England, 2017l). The analysis confirmed that SCRAs continue to impact the lives of inmates and staff across the prison estate, but prison staff are increasing in confidence and competence with regard to dealing with these issues. Examples of good practice to support the clinical and psychosocial management of the problems associated with NPS use were also noted.

5.9.2 North West 'Through the Gate Substance Misuse Services' Drug Testing Project

Between December 2014 and March 2015, in a study funded by the then Department of Health (DH) and the Home Office, urine samples from ten prisons across the north-west of England were screened as a key element of the 'Through the Gate' Substance Misuse Services Project and the wider Transforming Rehabilitation agenda. Samples from prisoners on reception to and at pre-release from prison were tested, as well as those from voluntary drug testing programmes and samples that tested negative using the MDT regime in place at the time. The study used the most up-to-date screening programme to detect traditional drugs, NPS, steroids and medications, and compared findings with the 'spice' immunoassay test being used in prisons at that time. Results of this project were published in June 2017 (National Offender Management Service & LGC, 2017). While cannabis and cocaine were the most frequently detected substances on arrival to prison (25% of on-reception testing positive for each of these substances), SCRAs as a group were the most commonly found substances in the samples taken from prisoners pre-release, present in 16% of these samples. Prevalence of SCRAs actually doubled in prison, increasing from eight per cent of samples on admission from the community. The study also found that the immunoassay kit that had been previously used within prison establishments for the detection of NPS was not viable, as it only detected seven per cent of the positive tests identified by the screening programme in one prison. Results from the study are discussed in section 5.3.

5.9.3 Prison drug recovery wing pilots evaluation

In October 2017, an evaluation of the prison drug recovery wing pilots was published, commissioned by the DH (Lloyd et al., 2017). The pilots were originally announced as part of the 2010 drug strategy (Her Majesty's Government, 2010) and in the *Breaking the Cycle* green paper (Ministry of Justice, 2010), and were launched in ten prisons in England and Wales over 2011 and 2012. Prisons were able to decide the model of the wing to reflect their particular needs, but all had the intention of delivering abstinence-focused services. As a result, the wings in each of the eight men's and two women's prisons differed in their population, size, aims, regime and intensity.

The wings in HMPs Manchester, Styal and Swansea were found to be promising models that improved prisoners' quality of life. Important features of these wings were the separation of clients from the rest of the prison; protection of beds for those engaged in the programme; a strong sense of community; and good relations between staff and prisoners. However, none of these features were deemed to be necessary or sufficient. Additionally, in all but one of the pilots, drug availability remained a problem. With regard to future provision, the authors suggested that small, intensive regimes such as that in HMP Manchester showed promise, which may be enhanced by linking to residential programmes on release.

The experiences of prisoners on release were found to be of concern as prisoners often went from a period of intensive support to a situation where they received little or no professional support, described by the authors as a 'cliff face'. As such, some drug recovery wings had excellent services delivered by highly motivated staff, but without help on release, these efforts could not substantially change people's lives.

5.9.4 Effect of opioid substitution treatment on mortality following release from prison

Marsden et al published a prospective observation cohort study examining the effect of exposure to OST in prison in England on the risk of death after prison release in 2017 (Marsden et al., 2017). The group found that prison-based OST was associated with a 75% reduction in all-cause mortality and an 85% reduction in fatal drug-related poisonings in the first month after release; however, there was no effect on mortality rate after the first month. See section 6.9.3 for further information.

5.9.5 Prisons and Probation Ombudsman bulletin on substance-related deaths in approved premises

The PPO published a learning lessons bulletin looking into deaths due to substance misuse occurring in approved premises in November 2017 (Prisons and Probation Ombudsman, 2017a).[72] This report highlighted the importance of drug testing, which can enable those managing the offender to make effective decisions about their substance misuse. The bulletin also stated the importance of reviewing all types of substances that the offender is at risk of using, in particular opioids, given the higher likelihood of opioid-related deaths in this population. Testing for all substances (including NPS) and information sharing were seen as other priorities, and the PPO identified a need for routine interactions and checks with residents to have a clear purpose.

5.9.6 Reducing prescription medication use in prisons in Northern Ireland

In 2017, NIPS and SEHSCT worked together to implement a pilot project aimed at reducing the level of prescribed medication within Maghaberry Prison. STEPS (formally known as The Lagan Project) uses a multi-disciplinary approach to reduce the dependence on pain medication by providing a programme of activity and alternative options for the prisoner.

5.9.7 Smoke-free legislation

The *Health Act 2006* (Her Majesty's Government, 2006) enacted in 2007 meant that smoking was no longer permitted in substantially enclosed public places in England (similar bans had already been implemented in Scotland, Wales and Northern Ireland). Prisons were exempt from this ban and prisoners remained able to smoke inside their cells. This led to a number of legal challenges, resulting in the Welsh Assembly committing to a full smoke-free policy being implemented from January 2016 in all prisons in Wales. In England, four early adopter sites (HMPs Exeter, Channing Wood, Dartmoor and Erlestoke) were chosen to become smoke-free as the first step of a phased approach to achieving an entirely smoke-free prison estate, and were smoke-free in both buildings and grounds by May 2016. As of 10 January 2018,

72 Approved premises were formerly known as probation or bail hostels. Most of the individuals in these premises have been released from prison on licence, and staff provide them with support and supervision, as well as monitoring individuals and enforcing their licence conditions

68 prisons in the closed estate in England and Wales were smoke-free,[73] with the remaining prisons due to be smoke-free by September 2018. E–cigarettes and nicotine replacement therapies (NRT) are available to buy in prisons, and NRT can be obtained as part of a stop smoking service intervention through prison health services. In addition to this, access to stop smoking support is being increased throughout the estate and every prison now has voluntary smoke-free accommodation.

The current position in Scotland is that prisoners are only permitted to smoke in their own cells and during outdoor recreation. Staff, visitors, and contractors are not permitted to smoke anywhere on SPS property. In March 2016 the Cabinet Secretary for Justice in Scotland accepted recommendations that all Scottish prisons should be smoke-free within a timescale of up to five years. In July 2017, in response to research into levels of second-hand smoke in Scottish prisons (Semple et al., 2017), SPS announced its intention to bring forward implementation of smoke-free prisons to November 2018. SPS will be working closely with NHS health boards and Scottish government as well as other partner agencies to develop comprehensive plans in preparation for the change. A decision has still to be made on whether e-cigarettes should be introduced to prisons in Scotland as part of moves towards smoke-free prisons.

In Northern Ireland, NIPS has set up a working group to consider the impact of passive smoking in prisons and is currently scoping the impact of the issue.

73 See: http://www.parliament.uk/business/publications/written-questions-answers-statements/written-question/Commons/2017-12-20/120564/

6 Drug-related deaths

6.1 Introduction

Drug-related death (DRD) is the third most common cause of preventable death among 15-49 year-olds in the UK.[75] In 2015, 3,070 deaths occurred in the UK that met the EMCDDA definition of drug misuse death. Seventy per cent (n=2,162) occurred in England; 21% (n=637) in Scotland; five per cent (n=167) in Wales and three per cent (n=104) in Northern Ireland. Almost three-quarters of DRDs in the UK were among men (n=2,262). The average age of those who died in 2015 was 42.1 years; the women who died were on average about three years older than the men. As in previous years, the majority of deaths in the UK (87%) involved some form of opioid.

The number of DRDs in the UK in 2015 marked a record high, surpassing the previous peak seen in 2009. Deaths fell markedly from 2009 to 2010, and remained relatively low during a period of reduced availability of heroin until starting to rise in 2013. This overall trend mainly reflects that seen for heroin-related deaths, given the high proportion of deaths involving this substance. There is an increasing trend towards deaths involving multiple drugs, and the average age of those dying has been rising over the past ten years, reflecting the ageing cohort of heroin users seen in the UK (see section 1.5.1).

Addressing the high numbers of DRDs is a priority objective in UK drug policy. Initiatives aimed at preventing deaths include the provision of take-home naloxone (THN), which is supported by national programmes in each of the devolved administrations.

6.2 Main drug-related deaths data sources and definitions

There are three General Mortality Registers (GMRs) in the UK: figures for England and Wales are both reported through a single GMR held by the Office for National Statistics (ONS), whereas Scotland and Northern Ireland each have separate registers. Official DRD statistics from England, Wales and Northern Ireland cover deaths where the underlying cause is drug abuse, drug dependence, or poisonings where any of the substances involved are scheduled under the *Misuse of Drugs Act 1971* (Her Majesty's Government, 1971). This is referred to as the drug misuse definition (DMD). DRDs in Scotland are identified by National Records of Scotland (NRS) requesting further information on all deaths involving drugs or persons known, or suspected, to be drug-dependent, or where the information on the death certificate is vague or suggests that there might be a background of drug abuse. This corresponds closely to the UK DMD.

In England and Wales, there are significant delays in registration of DRDs: for each year since 2007 the median delay has been between five and six months. Scotland is subject to different legislation around registration of deaths and experiences only minimal delays. This is problematic for reporting figures at the UK level, as the latest data on registrations from England and Wales is not up-to-date.[76] For UK totals in this report, the ONS GMR has been analysed to produce figures according to the year in which deaths occurred (referred to here as the EMCDDA definition)[77] rather than the year of registration. To ensure data on deaths occurring in

75 See: https://vizhub.healthdata.org/gbd-compare/england/

76 There are similar delays in Northern Ireland. However, as the number of cases this affects is much smaller, the difference is not expected to be problematic for reporting UK trends

77 Because of a lack of specific drug information for some deaths in England and Wales, it is likely that some deaths relating to illicit use continue to fall outside the EMCDDA definition

a given year is sufficiently complete despite the registration lags, the EMCDDA definition figures are always reported a year behind the latest year for which registration statistics are available.[78]

In official statistics produced by ONS, figures for England and Wales are routinely combined. However, for this report, separate figures for England and Wales are shown where the EMCDDA definition is used.

6.3 Numbers of drug-related deaths

Using the EMCDDA definition, the total number of DRDs in the UK during 2015 was 3,070, a 13% increase from 2014 (n=2,717), and the highest number reported to date (see accompanying table 4.1). In 2015, 2,162 DRDs were reported under the EMCDDA definition for England, which was 70% of the UK total. In Scotland, 637 deaths (21%) were reported, with 167 (five per cent) in Wales and 104 (three per cent) in Northern Ireland. Every country of the UK saw an increase in the number of deaths occurring in 2015 compared to 2014: the total for England was a 13% increase; Scotland experienced an increase of 11%; Wales saw an increase of 14%; and there was a 36% rise in Northern Ireland.[79]

The latest national statistics published for deaths registered in Scotland in 2016 showed that the number of DRDs increased steeply once more to a new record of 867, a 23% increase on those registered in 2015 (n=706) (National Records of Scotland, 2017). While not directly comparable (see section 6.2), the numbers of deaths registered in England and Wales in 2016 under the DMD were 2,383 in England (a four per cent increase from 2015 registrations; n=2,300) and 192 in Wales (a 14% increase from 2015 registrations; n=168) (Office for National Statistics, 2017a). It is therefore expected that once data on deaths occurring in 2016 is fully reported, this will show DRDs to have reached a new record high. In Northern Ireland, 111 drug misuse deaths were registered in 2016, a three per cent decrease from 2015 (n=114) (Northern Ireland Statistics and Research Agency, 2017a).

6.4 Profiling of drug-related deaths

Almost three-quarters (74%, n=2,262) of DRDs (EMCDDA definition) in 2015 were males (see Table 6.1). This proportion was similar across the UK, ranging from 71% in Northern Ireland and Scotland to 78% in Wales. The average age of those dying was 42.1 years; males tended to be about three years younger than females (41.3 years and 44.5 years respectively). The average age was lower in Scotland (41 years) than for the UK as a whole, particularly for women (42 years compared to 44.5 years). The average age was lower still in Northern Ireland (38 years), particularly for men (35 years). Sixty-three percent of those who died across the UK were aged between 30 and 49.

78 While the large majority of relevant deaths in a given year in England and Wales will have been registered by the end of the subsequent year, some DRDs have registration delays of over 12 months. Therefore, the figure first reported for a given year is provisional and will be revised upwards slightly in the next report to reflect this

79 Figures for England and Wales will still be somewhat incomplete for 2015, so they may ultimately make up a slightly greater proportion of the total

Table 6.1: Number of drug-related deaths in the United Kingdom occurring under the EMCDDA definition, by age and gender, 2015

	Total no. of cases	Mean age (years)	No. of cases by age group						
			Under 15 years	15-24 years	25-34 years	35-44 years	45-54 years	55-64 years	65 years and over
Male	2,262	41.34	0	118	512	819	552	191	70
Female	808	44.50	1	36	142	260	210	102	57
Total	3,070	42.11	1	154	654	1,079	762	293	127

Source: Accompanying table 4.2

Just over three-quarters of deaths (78%, 2,386 deaths) occurring in the UK in 2015 (EMCDDA definition) were accidental self-poisonings. There were 232 deaths reported as intentional self-poisonings, and 248 deaths were poisonings of undetermined intent (eight per cent each). The remaining five per cent of deaths were reported as mental and behavioural disorders due to psychoactive substance use.[80] Northern Ireland had a significantly higher proportion of deaths reported as 'undetermined intent' (79%), with only nine per cent reported as accidental poisonings.

6.5 Drug-related deaths by drugs reported

6.5.1 Proportion of deaths involving opioids

There were 2,656 deaths counted across the UK in 2015 using the EMCDDA definition which featured an opioid, representing 87% of the UK total. Eleven per cent involved non-opioid drugs without an opioid present (n=324), while three per cent of the total did not have any drug specified (n=89). The proportion of deaths featuring an opioid reported through each GMR in 2015 was highest in Scotland (91%), followed by Wales and England (85% each), with Northern Ireland slightly lower again, at 83% (see Table 6.2).

Table 6.2: Number of drug-related deaths where the class of drugs involved were known, occurring under the EMCDDA definition, 2015

Class of drug(s) involved	Number of cases (%)				
	England	Scotland	Wales	Northern Ireland	United Kingdom
Opioid (with or without non-opioid drugs)	1,846 (85.4%)	582 (91.4%)	142 (85.0%)	86 (83.5%)	2,656 (86.5%)
Non-opioid (without opioid present)	244 (11.3%)	44 (6.9%)	19 (11.4%)	17 (16.5%)	324 (10.6%)
No drug specified	72 (3.3%)	11 (1.7%)	6 (3.6%)	0 (0%)	89 (2.9%)
Total	2,162	637	167	103	3,069

Source: Accompanying table 4.3

80 Defined under the ICD-10 'F' codes

6.5.2 Substances implicated/mentioned in each General Mortality Register

The annual reports of each of the three GMRs in the UK provide a greater level of detail on substances mentioned or implicated in death than is currently available at UK level using the EMCDDA definition.

England and Wales

The most recent figures for England and Wales cover 2016 registrations reported using the DMD, as defined in section 6.2 (Office for National Statistics, 2017a). Of the 2,593 drug misuse deaths registered in this year, heroin/morphine was mentioned in 1,209 cases (47% of drug misuse deaths), similar to the number in 2015 (n=1,201; 48% of drug misuse deaths). The number of deaths mentioning heroin/morphine has more than doubled since 2012 (n=579), and the rate of heroin/morphine deaths per million population in 2016 was the highest on record (21.3 per million). Heroin was the only drug mentioned in 23% of drug misuse deaths (588 deaths). Methadone was mentioned in 413 cases (16% of deaths) in 2016 compared to 434 cases (18% of deaths) in 2015. Methadone was the only drug mentioned in 120 deaths (five per cent of deaths).

Tramadol, which became a controlled drug within the UK in June 2014 (Her Majesty's Government, 2014b), was mentioned in 184 deaths (seven per cent), continuing the decrease seen from when this drug was controlled (see section 6.6.3). It should be noted that tramadol deaths are automatically included in DRD statistics on account of tramadol being a controlled drug, and that many of these deaths are likely to have occurred among people using tramadol for medical reasons.

In total, 2,038 deaths registered in England and Wales in 2016 featured at least one opioid, disregarding those included as part of an analgesic compound. Just over one-quarter of deaths where at least one opioid was mentioned also had a mention of alcohol (528 deaths, 26%).

Cocaine was mentioned in 371 deaths (14%) in 2016, an increase of 16% from 2015 (n=320; the previous record number), and of 50% from the figure in 2014 (n=247). It is believed that the increase in heroin deaths where cocaine was also present accounts for a large part of this increase in cocaine-related deaths. Crack and powder forms of cocaine are not distinguished in DRD statistics. As crack is much more commonly used than powder by heroin users in England and Wales, it is likely that most deaths involving heroin and cocaine will relate to crack rather than powder. One-hundred and eight cocaine deaths occurred without another substance present (four per cent of deaths).

Benzodiazepines were mentioned in 406 deaths registered in 2016 in England and Wales, the highest figure since records began, accounting for 16% of deaths under the DMD. The number of deaths represented an 11% increase from the 366 cases registered in 2015. As seen in previous years, only a small number (n=17) of these cases did not also mention another drug.

The number of mentions of amphetamine in 2016 was 96, an increase from 90 deaths in 2015 and the highest number on record. MDMA was mentioned in 63 cases, also the highest number on record, increasing from 57 deaths in 2015.

Mentions of NPS increased to 123 (five per cent of drug misuse deaths), an eight per cent rise on 2015 (n=114). Previously the majority of NPS deaths were accounted for by mentions of cathinones (principally mephedrone) and GHB/GBL (which accounted for 30 deaths in 2016). However, the number of cathinone deaths decreased from 49 in 2015 (43% of NPS deaths) to 25 in 2016 (20% of NPS deaths), with the number of mephedrone deaths decreasing from 44 to 15 over the same time period. Synthetic cannabinoid receptor agonists (SCRAs) were

mentioned in a greater proportion of NPS deaths than previously recorded, with 27 deaths registered in 2016, an increase from eight in 2015. Benzodiazepine-type NPS were mentioned in 10 cases in 2016, a similar number to 2015 (n=11).

There were distinct differences in the age profile depending on the substances involved in deaths. The majority of deaths where NPS, cocaine or amphetamine were mentioned occurred in people under 40 years of age, while the reverse was true for deaths where opioids were mentioned. Deaths where benzodiazepines were mentioned occurred relatively evenly between people under 40 years of age, and those aged 40 and over.

Scotland

Opioids were implicated in 765 of the 867 deaths registered in Scotland in 2016, an increase of 26% from 2015 (n=606). The 765 cases represented 88% of all DRDs, a proportion that has remained stable since 2012. In 131 of these cases, only opioids (and possibly alcohol) were implicated in the death, a decrease from 197 deaths in 2015. Heroin/morphine was implicated in, or potentially contributed to, 473 deaths (55% of all deaths), with methadone involved in 362 cases (42%). Benzodiazepines were implicated in, or potentially contributed to, 426 deaths in 2016 (49% of all deaths), an increase of 123% on the 2015 figure. This is the highest number of cases recorded in Scotland in which benzodiazepines were reported, and greater even than the number of cases registered in England and Wales in 2016 where benzodiazepines were involved (n=406). Etizolam was implicated in, or contributed to, the largest proportion of these cases (n=225, up from 43 cases in 2015), with diazepam reported in 154 deaths (an increase from 121 in 2015). As with elsewhere in the UK, deaths where benzodiazepines were the only drug reported (though possibly with alcohol) were rare (n=4).

The number of cases where cocaine was implicated in, or potentially contributed to, the cause of death has more than doubled since 2014, from 45 to 123 cases in 2016 (14% of all deaths); however, it was the only drug reported in 19 deaths. Ecstasy-type substances were recorded in 28 deaths. Though this is a small proportion of Scotland's DRDs, it is large relative to the number of ecstasy-related deaths registered in England and Wales in 2016 (n=63) considering Scotland's smaller population. However, it should be noted that the category reported in the Scottish data is more broadly defined. Amphetamine was reported in 25 cases.

NPS were implicated in, or contributed to, 286 cases, almost four times the number of reports for deaths in 2015 (n=74). Almost all of these (97%) were benzodiazepine–type NPS (which are also counted under numbers of benzodiazepines deaths). Etizolam was the most commonly implicated of these NPS, contributing to 225 cases (78% of NPS deaths). Heroin, methadone or both were implicated alongside the benzodiazepine-type NPS in 230 cases (83% of benzodiazepine-type NPS deaths).

Northern Ireland

In 2016, there were 111 drug misuse deaths registered in Northern Ireland (Northern Ireland Statistics and Research Agency, 2017a). As seen in the rest of the UK, opioids were the most commonly mentioned substance group, being mentioned in 90 deaths (81% of deaths under the DMD). However, in contrast to the UK as a whole, tramadol was the most commonly mentioned opioid, mentioned in 33 deaths registered in 2016 (30% of drug misuse deaths), followed by heroin, mentioned in 25 deaths (23%). There was a sharp increase in the number of deaths involving fentanyl between 2014 and 2015, from one to 15 deaths (13% of drug misuse deaths). The proportion of drug misuse deaths mentioning fentanyl remained similar in 2016 (12%; n=13). As seen in previous years, the number of drug misuse deaths involving a benzodiazepine was high, with 65 deaths (59%) mentioning at least one of these substances on the death certificate. The number of deaths involving NPS (seven; of which one involved mephedrone) was the same

as the number of deaths involving MDMA (seven), and was more than double the number of deaths involving cocaine (three).

6.6 Trends in drug-related deaths

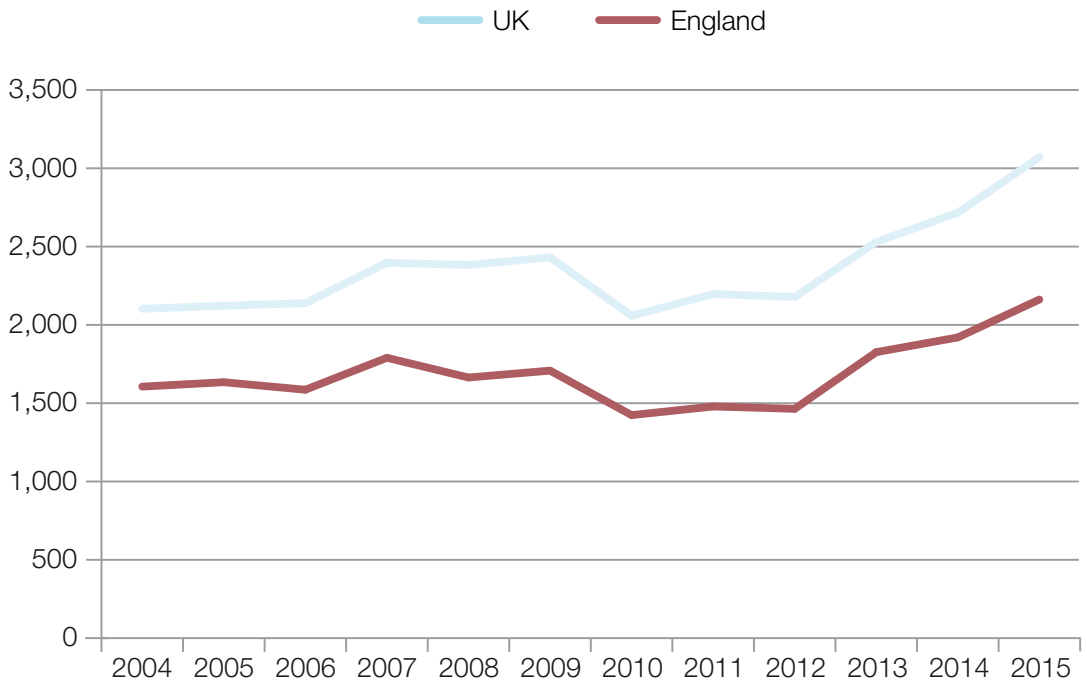
6.6.1 Numbers of deaths

Deaths recorded under the EMCDDA definition

Following a peak in 2009 (n=2,432), there was a sharp fall in DRDs in the UK in 2010 (to 2,058, a decrease of 15%). After a small rise in 2012, the number of deaths increased markedly in 2013, with further increases over the next two years. There were 3,070 deaths in the UK in 2015, which was 26% higher than the 2009 peak. Due to its greater population size, and thus greater proportion of the total number of deaths, trends in England followed the same trend as the UK over this period, and rose by 13% in 2015 (n=2,162) (see Figure 6.1). Deaths in Wales also peaked in 2009 (n=157) and fell to 113 in 2010 (see Figure 6.2). Following a small increase to 2013, there were further increases in the next two years to a record 167 deaths in 2015. Deaths in Northern Ireland have increased more gradually, rising from 31 in 2005 to 44 in 2012. In the following three years there have been larger increases, and in 2015 there were 104 deaths (a 35% increase on deaths in 2014; n=77). There were 637 deaths registered in Scotland in 2015, an 11% increase on the previous year (n=574). As in each other country of the UK, deaths in Scotland have increased markedly in the last ten years, although there has been greater variation in Scotland and England than in Wales and Northern Ireland.

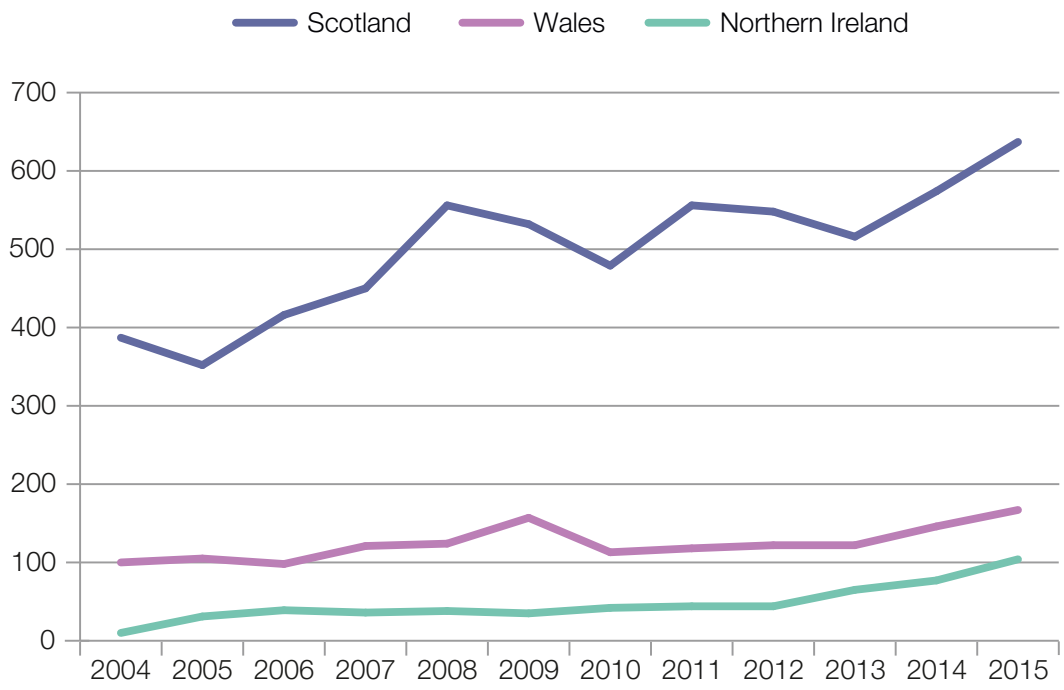
The number of deaths in 2016 which had already been registered by the end of the year suggests that when more complete data is available on deaths occurring in 2016 using the EMCDDA definition, this will show a fourth successive year-on-year increase in the total for the UK.

Figure 6.1: Number of drug-related deaths in the United Kingdom and England under the EMCDDA definition, occurring in 2004 to 2015



Source: Accompanying table 4.4

Figure 6.2: Number of drug-related deaths in Scotland, Wales and Northern Ireland under the EMCDDA definition, occurring in 2004 to 2015

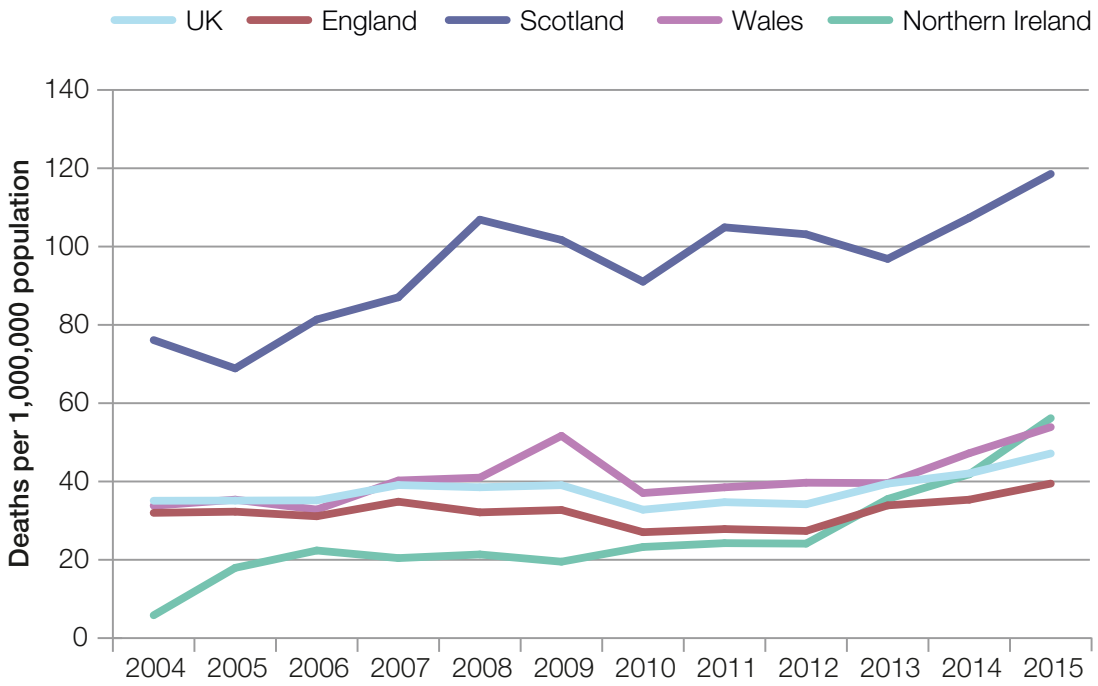


Source: Accompanying table 4.4

6.6.2 Mortality rates

Drug-related mortality rates in each country of the UK show long-term upward trends (see Figure 6.3). In 2015 the mortality rate for the UK as a whole was 47.2 deaths per million population. The rate in England was slightly lower than the average for the UK (39.5 deaths per million), with Wales (53.9 deaths per million) and Northern Ireland (56.2 deaths per million) both slightly higher than the UK figure. As has been the case for the whole time series, the mortality rate for Scotland was the highest in the UK, with the 2015 figure (118.6 deaths per million) more than double the average for the UK.

Figure 6.3: Mortality rate (deaths per million population) for drug-related deaths occurring under the EMCDDA definition in the United Kingdom, England, Scotland, Wales and Northern Ireland, 2004 to 2015



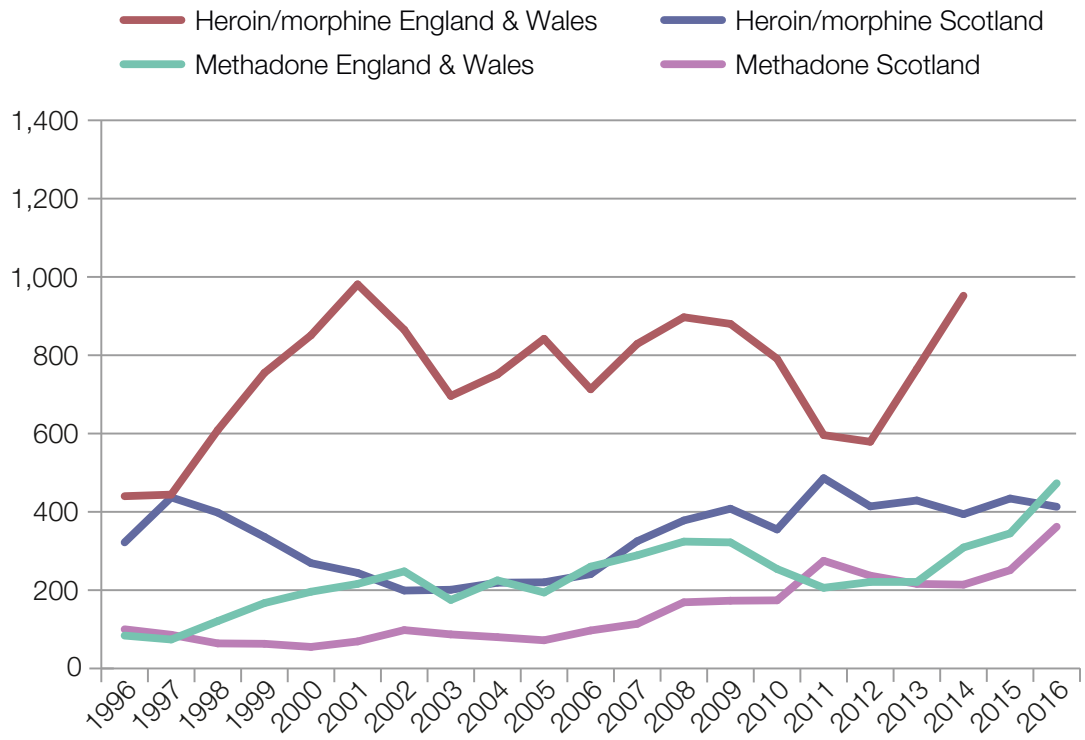
Source: Accompanying table 4.4, (Office for National Statistics, 2017b)

6.6.3 Substances implicated/mentioned

Trends in the substances implicated/mentioned in deaths are presented by GMR below. Data for England, Wales and Northern Ireland is provided for all drug poisoning deaths where a substance is mentioned on the death certificate, whereas the Scottish data from 2008 onwards represents specifically where a drug was implicated in, or potentially contributed to, the cause of death. It should be noted that due to registration delays, deaths outside of Scotland will often be reported against the year after they occurred.

Heroin is the most commonly mentioned drug at death in England & Wales and Scotland; however, in 1996, 1997, 2011 and 2012 methadone was more commonly mentioned than heroin in Scotland (see Figure 6.4). The difference between methadone and heroin deaths in England and Wales also reduced in 2011 and 2012, during which time there was a decrease in heroin availability (see section 1.5.1). There are relatively few deaths involving buprenorphine in the UK (data not shown).

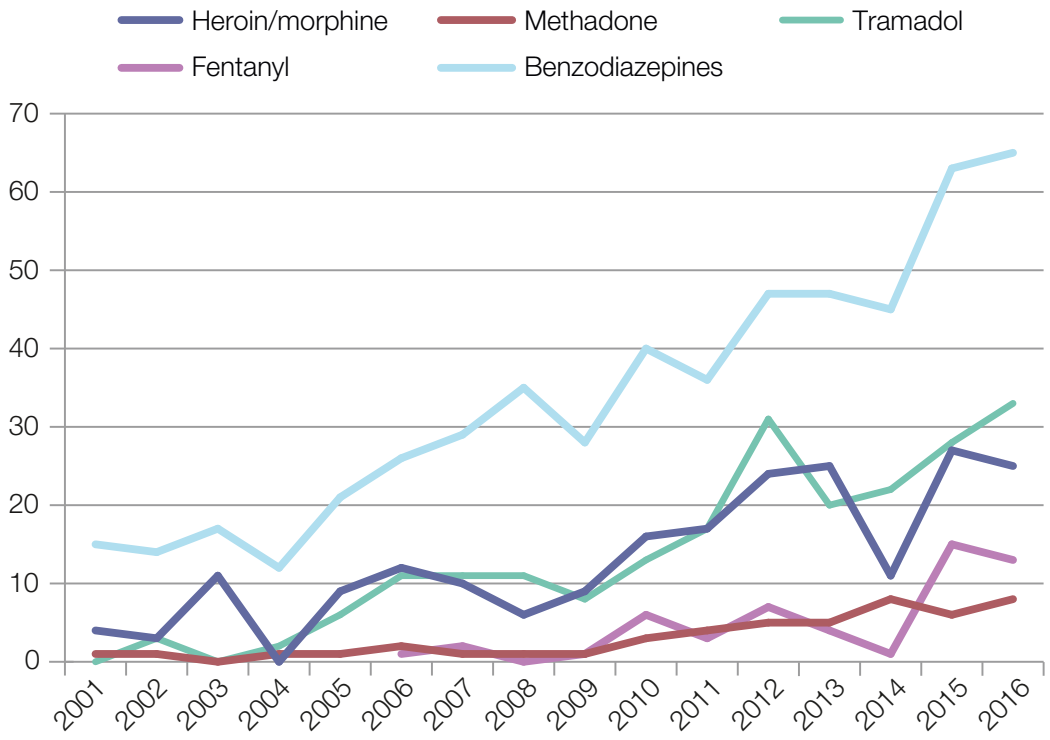
Figure 6.4: Number of drug-related deaths where heroin/morphine or methadone were mentioned on the death certificate in England & Wales, or were implicated, or possibly contributed to the cause of death in Scotland, registered in 1996 to 2016



Source: (National Records of Scotland, 2017) (Office for National Statistics, 2017a)

The number of deaths in England and Wales where benzodiazepines were mentioned on the death certificate has more than doubled since 2006 (from 177 deaths, the lowest number in the time series, to 406 deaths in 2016). In 2002, benzodiazepines were mentioned in more deaths in Scotland than in England and Wales combined (245 deaths in Scotland, 241 deaths in England and Wales), but then fell to a nadir in 2006 (n=94) while benzodiazepine deaths in England and Wales rose. The number of cases has been increasing in recent years, and in 2016, benzodiazepine-related deaths in Scotland markedly increased, from 191 in 2015 to 426. This number is the highest annual number of cases recorded in both registers. Northern Ireland also saw its highest number of benzodiazepine-related deaths in this year (n=65; see Figure 6.5). The rise in Scotland in the past year is predominantly due to an increase in the number of deaths where benzodiazepine-type NPS were involved, from 74 cases in 2015 to 286 cases in 2016. While the number of deaths involving diazepam increased between 2014 and 2016, from 84 to 154, the figure for 2016 is still lower than the number of diazepam-related deaths in 2002 (n=214).

Figure 6.5: Number of drug-related deaths in Northern Ireland where heroin/morphine, methadone, tramadol, fentanyl or benzodiazepines were mentioned on the death certificate, or were implicated, registered in 2001 to 2016*



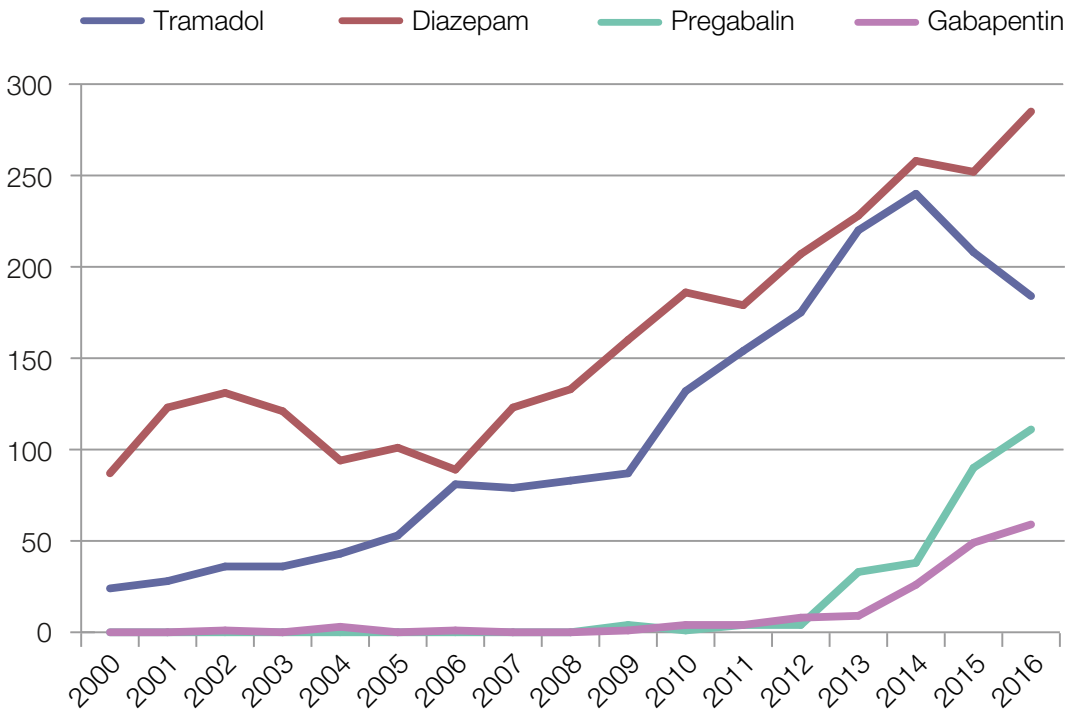
* Data only available from 2006

Source: (Northern Ireland Statistics and Research Agency, 2015, 2017a)

The total number of tramadol deaths registered on the three GMRs in 2015 (n=289) represented the first decrease in total UK tramadol deaths since the first registered death in 1996. Tramadol prescriptions have continued to decrease since 2013, after a long-term rising trend. However, while early indications suggest that the control of tramadol in June 2014 may have led to a reduction in tramadol poisonings, registration delays in England and Wales mean that the time period for which there is complete data for DRDs following the control is limited.

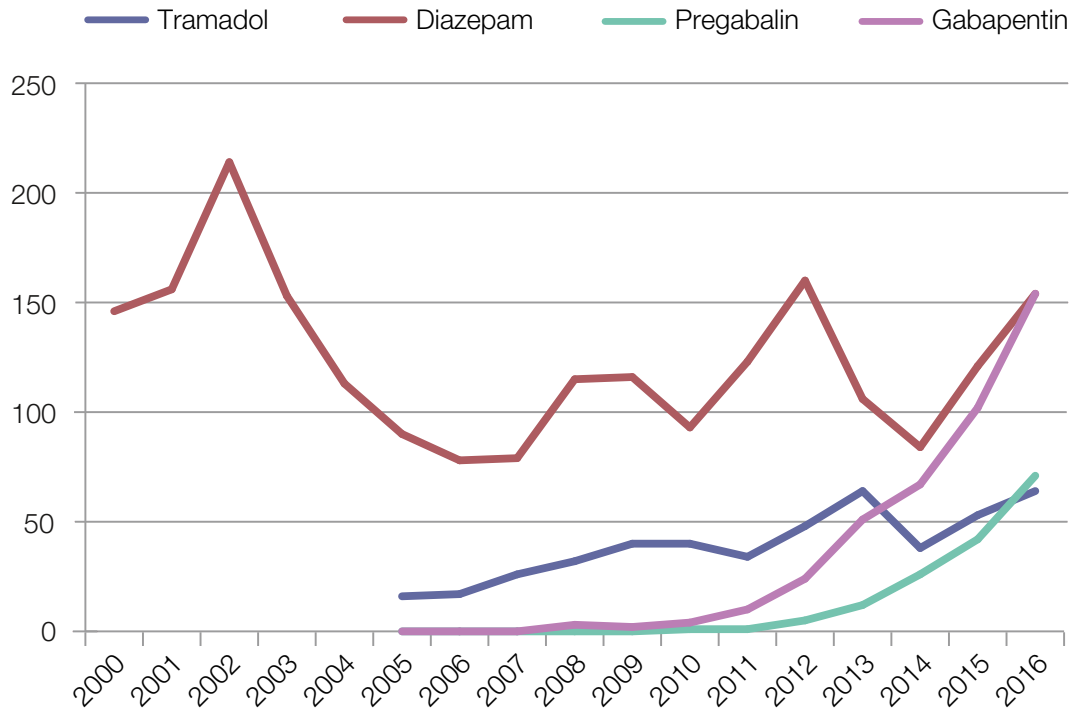
The numbers of deaths in England and Wales involving pregabalin and gabapentin have risen markedly since 2013, from 33 and nine to 111 and 59 in 2016, respectively, with the largest increase in deaths occurring in 2015 (Figure 6.6). In the same period in Scotland, gabapentin was implicated or involved in an increasing number of deaths; from 51 to 154, and pregabalin increased from 12 to 71 (Figure 6.7). Pregabalin was mentioned in one death in Northern Ireland in 2013, and mentions increased to eight in 2016 (Figure 6.5).

Figure 6.6: Number of drug-related deaths where selected prescription medications susceptible to misuse were mentioned on the death certificate registered in England and Wales, 2000 to 2016



Source: (Office for National Statistics, 2017a)

Figure 6.7: Number of drug-related deaths where selected prescription medications susceptible to misuse were implicated in, or contributed to, the cause of death registered in Scotland, 2000 to 2016

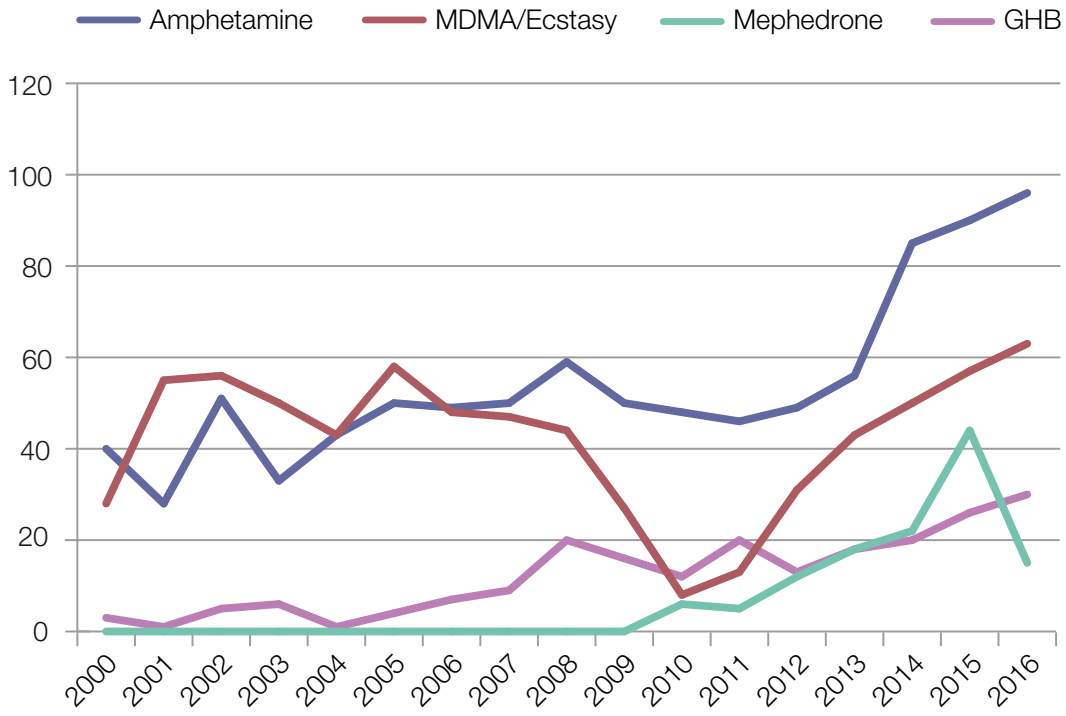


Source: (National Records of Scotland, 2017)

MDMA/ecstasy-type deaths decreased to a nadir in both the England & Wales and Scotland registers in 2010, following a decrease in the global availability of MDMA in the late 2000s (see section 1.4.4), and have since returned to a similar number to that seen between 2001 and 2008, with deaths registered in 2016 the highest number on record in both GMRs (see Figure 6.8 and Figure 6.9). Since 2012, the number of deaths involving GHB has risen steadily in England and Wales, and this substance was mentioned in more deaths than cathinones in 2016 (GHB: n=30; cathinones: n=25). Deaths related to amphetamine have more than doubled in both registers since 2000, with a particularly noticeable increase in England and Wales between 2013 and 2014.

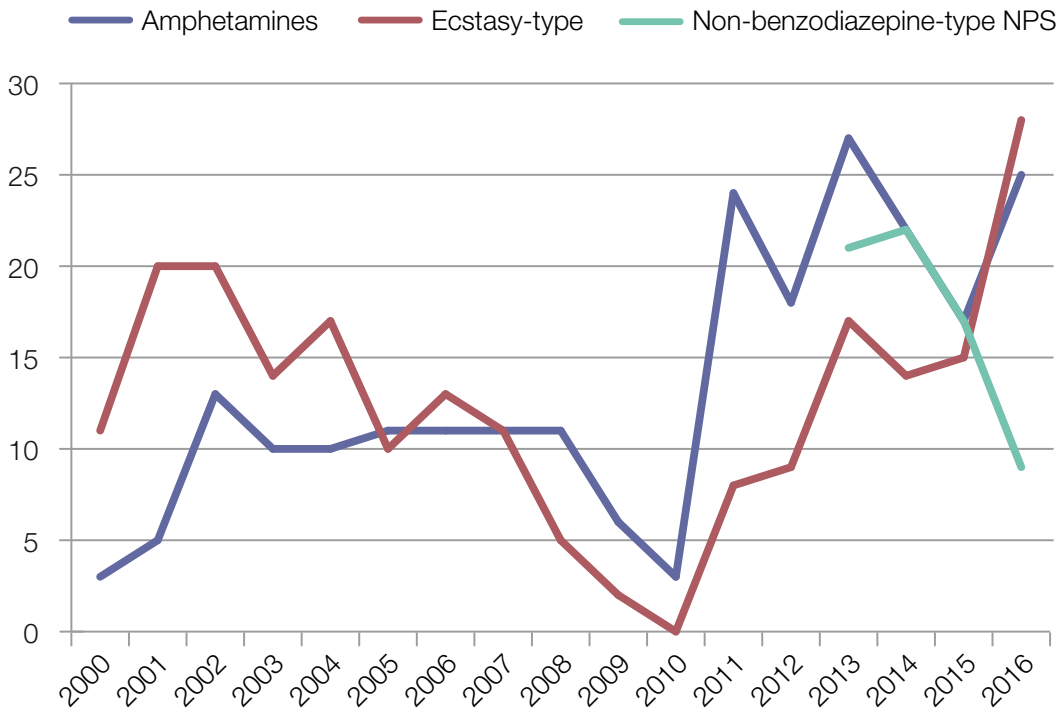
Deaths involving NPS have increased greatly since 2010 in both England & Wales and Scotland (data not shown on graphs). There were similar numbers of deaths in both registers in 2015; however, in 2016 deaths involving NPS in Scotland rose dramatically to over three times the number seen in 2015 (principally due to etizolam), while the number of deaths registered in England & Wales remained stable. The nature of the NPS involved in deaths differs between the two registers, as cathinones (mainly mephedrone) have been responsible for the largest proportion of NPS deaths in England and Wales since they were first recorded in 2010, whereas benzodiazepine-type substances were implicated in 98% of deaths involving NPS in Scotland in 2016. Deaths in England and Wales involving SCRAs have risen since 2014, with three times as many deaths reported in 2016 (n=27) as the previous year (n=8).

Figure 6.8: Number of drug-related deaths where amphetamine, MDMA and ecstasy-type drugs, GHB and mephedrone were mentioned on the death certificate registered in England and Wales, 2000 to 2016



Source: (Office for National Statistics, 2017a)

Figure 6.9: Number of drug-related deaths where amphetamine, ecstasy-type substances and non-benzodiazepine-type new psychoactive substances were implicated in, or potentially contributed to, the death registered in Scotland, 2000 to 2016*



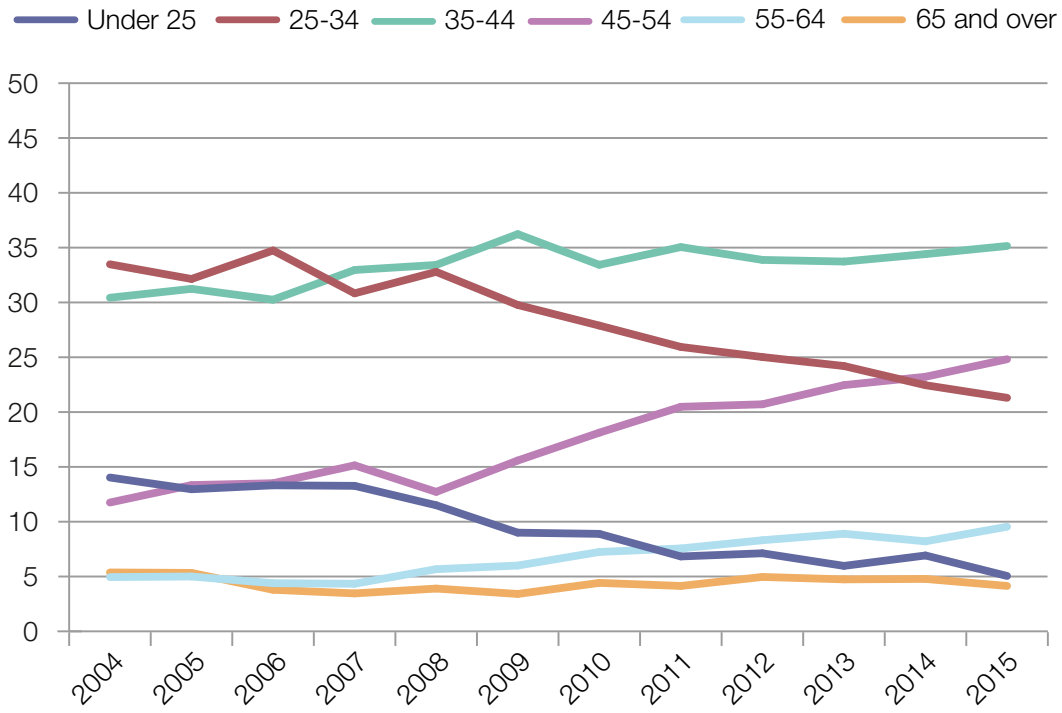
*Data only available from 2013

Source: (National Records of Scotland, 2017)

6.6.4 Age

The UK has seen long-term increases in the proportions of DRDs occurring in older age groups, and decreases in the proportions occurring in younger age groups (see Figure 6.10). Overall, 35% of deaths occurring in the UK in 2015 were of those in the 35-44 years age group (n=1,079), and 25% occurred in the 45-54 years age group (n=762). From a peak in 2006, the proportion of deaths occurring in those under the age of 35 has decreased markedly, from accounting for 48% of deaths in 2006 to 26% in 2015. The proportion of deaths occurring in those aged 45 and over has increased over the same period, from 22% in 2006 to 39% in 2015.

Figure 6.10: Proportion of all drug-related deaths in the United Kingdom occurring under the EMCDDA definition, by age-group, 2004 to 2015

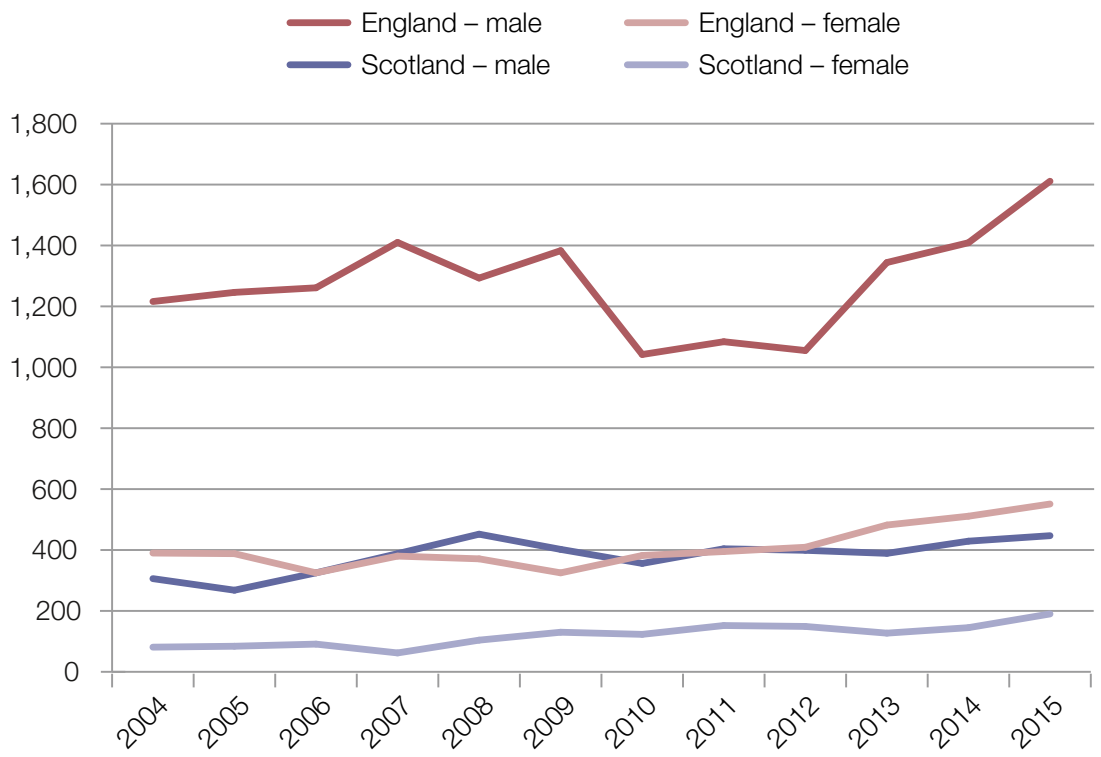


Source: Accompanying table 4.7

6.6.5 Gender

Males account for around three-quarters of DRDs in the UK (74% for the EMCDDA definition in 2015). After fluctuating between 460 and 541 between 2004 and 2010, the number of female deaths has since increased, and was 808 in 2015 (a 49% increase from 2010). The number of male deaths has fluctuated to a greater degree over time (see Figure 6.11), with the peaks and troughs seen in the overall trend mainly reflective of the trend among men.

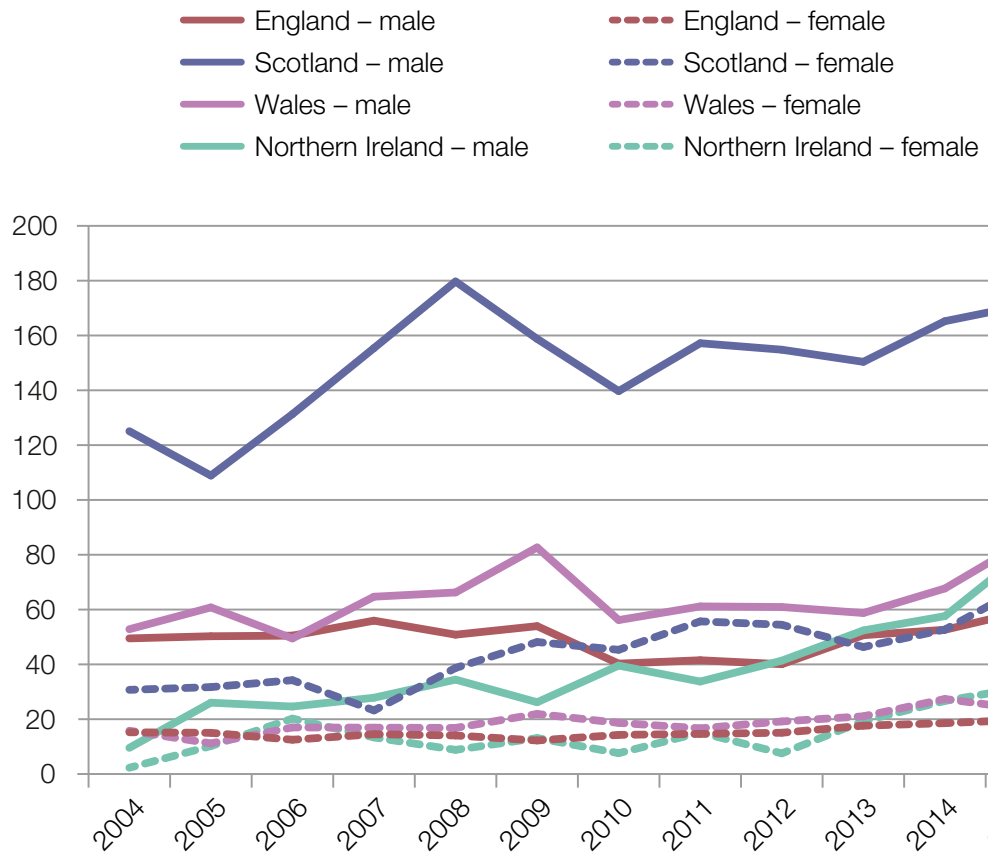
Figure 6.11: Number of drug-related deaths occurring under the EMCDDA definition in England and Scotland, by gender, 2004 to 2015



Source: Accompanying table 4.5

The patterns seen in Scotland and Wales are similar to that seen in England, with the number of female deaths rising more steadily than the number of male deaths throughout most of the time series (due to the lower numbers involved, there is greater variability in Northern Ireland). However, the rise in female deaths was particularly steep in Scotland between 2013 and 2015: the number of female deaths increased by 50%, compared to a 15% increase in male deaths over the same period (females: 127 to 190; males: 389 to 447). In contrast, the number of female deaths in Wales in 2015 decreased from the 2014 figure (43 in 2014; 37 in 2015). The trends in deaths for each gender in each country are shown in Figure 6.12 as mortality rates for comparability.

Figure 6.12: Mortality rate (deaths per million population) for drug-related deaths in England, Scotland, Wales and Northern Ireland occurring under the EMCDDA definition, by gender, 2004 to 2015



Source: Accompanying table 4.5, (Office for National Statistics, 2017b)

6.7 Complementary sources of data

6.7.1 National Drug-Related Deaths Database (Scotland)

The most recent report from the National Drug-Related Deaths Database (NDRDD) in Scotland was published in March 2016, examining the circumstances of those who died a DRD in Scotland in 2014 (Information Services Division, 2016a). The DRDs in the NDRDD report were a sub-set of the 613 DRDs published by NRS in August 2015 (National Records of Scotland, 2015). The NDRDD includes the most detailed information on DRDs of any national database in the UK. Statistics reported in this publication include details on substance use history (including treatment history and whether opioid substitution treatment (OST) was prescribed), circumstances of death (for example, in what setting the death occurred, whether anyone was present and whether naloxone was available) and previous overdoses, among other variables.

6.7.2 National Programme on Substance Abuse Deaths (England, Northern Ireland, the Channel Islands and the Isle of Man)

The National Programme on Substance Abuse Deaths (NPSAD) reports on DRDs based on a specific definition which may include deaths that are not normally within the scope of the DMD. The most recent NPSAD report was published in September 2015 (Claridge & Goodair, 2015).

This report covered DRDs in England, Northern Ireland, the Channel Islands and the Isle of Man occurring in 2013.

6.8 Naloxone

In the UK, naloxone is used in hospitals and carried routinely on ambulances to treat patients suffering from severe respiratory depression following an opioid overdose. There are national naloxone programmes in Scotland, Wales and Northern Ireland which facilitate the distribution of naloxone in non-clinical settings such as hostels. These programmes also facilitate the distribution of naloxone kits to those at risk of overdose (including individuals at the point of release from prison) or to their families and carers. While no equivalent national programme exists in England, distribution of THN is common.

6.8.1 Provision of naloxone

England

In July 2017 the Local Government Association published the results of a survey examining the provision of naloxone by LAs in England (Local Government Association, 2017). The *Naloxone survey 2017* received 120 responses, representing 135 LAs in total (89% of 152 authorities in England), as 29 responses covered more than one authority.

Ninety per cent of responding authorities reported that they currently make THN available. Of those authorities: 99% provided it through drug treatment services; 25% through hostels; and 25% through use of outreach workers. In addition, of those authorities that made naloxone available: 95% provided it to treatment service users; 79% to family/friends/carers of opioid users; and 64% to opioid users not in treatment. Seventy-six per cent of those that make naloxone available have a provision policy or framework in place.

Fifty per cent of the responding authorities that do not currently make naloxone available (n=14) indicated that they would do so if opioid overdoses or DRDs increased in their area. Twenty-nine per cent of respondents that do not currently make naloxone available cited the low number of opioid-related deaths in their area as a factor in their decisions, and 21% cited the low number of opioid overdoses.

Research published by Release,[81] analysing the LAs' responses to the *Naloxone survey 2017* (obtained by Freedom of Information requests), further examined the provision of THN in England, beyond the number of LAs that currently make it available. The analysis raised concerns about unnecessary barriers to access kits, the quantity of THN kits dispensed, and ineffective targeting of high risk groups. A number of recommendations were made, including: making kits available to any person requesting THN (at least one per person using opioids) in their area; removing requirements for an individual to have engaged with local services prior to being dispensed a kit; enhancing data collection and monitoring of provision by LAs; and increasing national co-ordination and support for LAs in order to assist with detecting and addressing gaps.

Scotland

During 2016/17, 8,159 THN kits were issued in Scotland, a decrease of one per cent from the previous year (n=8,273) (Information Services Division, 2017d). Of these kits, 6,497 were issued in the community, an 11% decrease compared to the previous year (n=7,271). Seven hundred kits were issued to prisoners at the point of release from prison, and 962 kits were supplied

81 See: https://www.release.org.uk/naloxone

by community prescription. THN supply via community prescription began in April 2013, and markedly increased as a proportion of the overall number of THN kits issued in 2016/17 (12%, compared to one per cent in the previous year).

Between April 2011 and March 2017, the Scottish national THN programme issued 37,609 THN kits, including kits issued in the community, via community prescription and from prison. The supply of kits per problem drug user has more than doubled, from 52 kits per 1,000 problem drug users in 2011/12 to 133 per 1,000 in 2016/17. The percentage of kits distributed as a repeat supply increased each year, from 12% in 2011/12 to 48% in 2016/17. In addition, 882 repeat kit supplies were made in 2016/17 because the previous kit was reported as having been used to treat an opioid overdose.

Wales

Data from the Harm Reduction Database showed that 1,709 THN kits were distributed to new THN clients in Wales in 2016/17, with a further 2,778 kits being issued as re-supplies (Public Health Wales, 2017). This represented a 41% increase on the total number of kits supplied in 2015/16 (n=3,186). Between 1 July 2009 and 31 March 2017, 15,037 kits were distributed within the country. THN was reported to have been used in 589 drug poisoning events in Wales in 2016/17; most commonly administered to a third party (n=492; 84%). Death was reported in less than two per cent of cases where naloxone was administered in 2016/17.

6.8.2 Self-reported overdose and receipt of naloxone

Research published in August 2017 provided the first data on self-reported overdose and receipt of naloxone among people who inject drugs (PWID) in England, Wales and Northern Ireland, creating a baseline measure to enable monitoring in future (O'Halloran et al., 2017). A question on overdoses and naloxone use was added to the Unlinked Anonymous Monitoring (UAM) survey of PWID in 2013. Of the 3,850 participants responding to the survey in 2013 and 2014, 15% (n=591) reported overdosing to unconsciousness in the past year. Eighty-one per cent (n=477) of these individuals were able to answer whether they had received naloxone or not: 213 (45%) of these individuals reported that naloxone had been used when they had overdosed. However, the survey does not currently ask respondents who administered the naloxone (for example whether by a witness or a paramedic).

It was found that overdose in the preceding year was more common among those who reported: having previously been prescribed OST or detoxification medication (as opposed to those who were currently receiving or who had never been prescribed one of these medications); injecting multiple drugs; injecting with used needles/syringes; recently ceasing treatment; ingesting benzodiazepines in the past month; ever having transactional sex; and ever using a sexual health clinic or emergency department. Those living in Wales or Northern Ireland were more likely to have overdosed than those living in England.

In November 2017, Public Health England (PHE) published *Non-fatal overdose among people who inject drugs in England: 2017,* providing the first summary report on the data generated by the questions added to the UAM in 2013, to the end of 2016 (Public Health England, 2017i). This publication showed that the proportion of PWID reporting overdosing in the past year increased annually from the 15% baseline, to 17%, 18% and 19% in the following three years respectively. The proportion of those who were able to answer as to whether naloxone was used when they had overdosed in the past year increased from 42% in 2013 to 47%.

In 2013, 21% of recent initiates (those who had started injecting within the preceding three years) reported having overdosed, compared to 14% of those who had been injecting for longer.

In the following three years the difference has narrowed, and in 2016 a smaller proportion of recent initiates (18%) reported overdosing than non-recent initiates (19%).

With regard to treatment status, in 2016 self-reported overdose was highest among those who had previously been in treatment, but were not currently (31%), and lowest among those currently in treatment (16%). Overdose was reported by 21% of those who had never been in treatment. Among PWID who reported overdosing in the preceding year in 2016, 49% reported overdosing once, 42% reported overdosing two to four times, five per cent reported five to nine occurrences and four per cent overdosed ten or more times.

6.9 New developments

6.9.1 Advisory Council on the Misuse of Drugs report on drug-related deaths

The Advisory Council on the Misuse of Drugs (ACMD) convened a working group to examine how to reduce DRDs, focusing in particular on opioid-related deaths. The resulting report, *Reducing Opioid-related Deaths,* was submitted to the Home Secretary in December 2016, and made nine recommendations to central and local government, drug treatment service commissioners and providers, coroners and research funders (Advisory Council on the Misuse of Drugs, 2016b). Recommendations included: developing strategies to protect current investment in evidence-based treatment; continuing investment in OST of optimal dosage and duration alongside wider recovery interventions; providing OST and tailored treatment in line with guidelines; funding heroin-assisted treatment for individuals for whom other OST has not been effective; and making naloxone routinely available for those who use opioids, their families and friends. Other recommendations included creating data standards for local reporting that feeds into national systems; providing an integrated approach for drug users at risk of DRD; prioritising funding and access to physical and mental health and social care services; and funding research to fill important gaps in the literature on the causes and prevention of opioid-related deaths. In addition, the ACMD recommended considering the potential to reduce DRDs and other harms through the provision of medically-supervised drug consumption clinics in localities with a high concentration of injecting drug use. The Home Office and the then Department of Health issued a joint response on behalf of the UK government in July 2017, setting out the work that will be undertaken to address the advice (Department of Health & Home Office, 2017).

6.9.2 NHS Health Scotland rapid evidence review on drug-related deaths

In order to inform discussions at a conference convened in July 2017, responding to rising DRDs in Scotland, NHS Health Scotland carried out a rapid evidence review of the risks and needs of people aged 35 and over who experience harms related to their drug use. A follow-up report presenting the appraisal of relevant systematic reviews and grey literature reports, *Drugs-related deaths rapid evidence review: Keeping people safe, was published in October 2017* (NHS Health Scotland, 2017).

Findings from the review suggested that: OST safeguards the health of those with opioid dependence; medications should be considered based on an individual level; treatment approaches and services require individual tailoring to support staying in treatment; the first four weeks of treatment and the first four after leaving are critical points of intervention to reduce mortality risk; and harm reduction and treatment services effectively reduce the transmission of blood-borne viruses. Other key points included: psychosocial interventions alongside medication-assisted treatment has been shown to improve outcomes for those with opioid

dependence; complex psychological and social barriers must be addressed in order to support individuals accessing services; THN programmes improve knowledge and management of overdose and increase the likelihood of recovery from overdose; and the effectiveness and retention of interventions improves when designs are holistic and tailored to individuals' health and social needs.

6.9.3 Fentanyls incident

Although official statistics are not yet available for deaths occurring or registered in 2017, a number of localised spikes of overdose deaths in England (mostly in Yorkshire and the Humber) were noticed in the first half of 2017, leading to alerts being issued by PHE and the National Crime Agency (NCA). Toxicological testing confirmed that fentanyl analogues were present in over 80 cases associated with the incident, and that carfentanyl was involved in the majority of these cases. The presence of fentanyls in the heroin supply chain was traced by the NCA to a small number of dark net vendors; these vendors were arrested, and no further deaths have been linked to this incident since June 2017 (see section 9.5.1). While it is encouraging that no similar incident has occurred in the UK since, the possibility of future incidents is of obvious concern and efforts are being made to ensure all relevant parties are suitably prepared should something similar happen again.

6.9.4 Mortality cohort studies

Opioid substitution treatment in prison and death after release

Marsden et al conducted a prospective observation cohort study examining the effect of exposure to OST in prison in England on the risk of death after prison release (Marsden et al., 2017). The study recruited 15,141 prisoners with a diagnosed opioid use disorder from 32 male and seven female adult prisons in England. They were classified as either OST exposed or OST unexposed, with the OST unexposed individuals having either not received OST, been withdrawn from OST, or having received a low dose of OST. The following outcomes were measured: all-cause mortality (ACM) and drug-related poisoning (DRP) deaths in the first four weeks after release; ACM and DRP mortality four weeks to one year after release; and admission to community drug misuse treatment within the four weeks after release.

In the first four weeks after release from prison there were 24 ACM deaths: six in the OST exposed group, and 18 in the OST unexposed group (mortality rates of 0.93 per 100 person-years (py) in OST exposed versus 3.67 per 100 py in OST unexposed). There were 18 DRP deaths recorded in the four weeks after release: three in the OST exposed group, and 15 in the OST unexposed group (mortality rates of 0.47 per 100 py versus 3.06 per 100 py respectively). Within four weeks of release 6,140 (41%) of those released entered community drug treatment, with the OST exposed group more likely to enter treatment (odds ratio 2.47). In the first year after release there were 160 ACM deaths, of which 102 were DRP deaths (mortality rates of 1.22 per 100 py and 0.78 per py respectively). After adjustment for potential confounding, prison-based OST was associated with a 75% reduction in ACM and an 85% reduction in fatal DRP in the first month after release.

Evidence of a vulnerable cohort of young men living in deprived areas among Scottish drug-related deaths

Parkinson et al conducted a retrospective analysis of DRDs in Scotland (using the ONS 'wide' definition[82] for drug poisoning, as referred to in Scottish GMR publications), by sex and deprivation,

82 This definition is broader and not restricted to illicit drugs, therefore figures are higher

to examine if age, period or cohort effects, as a result of exposure to changing political contexts, could explain recent trends (Parkinson, Minton, Lewsey, Bouttell, & McCartney, 2017). They identified a cohort effect, particularly among males living in the most deprived areas, with those born between 1960 and 1980 at increased risk of DRD. The highest risk was identified in those born between 1970 and 1975. A weaker cohort effect among females in the most deprived areas born between 1965 and 1980 was also observed.

6.9.5 Observed rise in GHB-associated deaths in London

Research carried out by forensic scientists in London identified 61 GHB-associated deaths occurring in the city between 2011 and 2015, by retrospective toxicology analysis, with almost half (n=29) occurring in 2015 alone (Hockenhull et al., 2017). All but one of the deaths were in males, and 84% were aged 30 and over. In 65% of the cases, mephedrone and/or methamphetamine were detected, and in 25% of the cases chemsex was mentioned in the case history. The authors therefore reported that there has been an increase in the number of GHB-associated deaths in London in 2015, and that this is likely to be due, at least in part, to increasing use of GHB for chemsex.

7 Drug-related infectious diseases and other harms

7.1 Introduction

People who use drugs are at risk of various types of harms, from those that directly affect the individual to those that affect the larger drug-using population. Such harms include drug-induced toxicity, the contraction of blood-borne viruses (BBVs) through injecting drug use, and other harms related to drug injection, for example skin and soft tissue infections. Harm reduction programmes aimed at injecting drug users have traditionally focused on reducing the rates of infection and transmission, increasing the diagnosis of current infections, and improving the provision of treatment and support to infected individuals. This is often achieved through specialist programmes and initiatives, such as needle and syringe provision and vaccinations against BBVs.

In the UK, injecting drug use is the principal risk factor for contracting hepatitis C. In 2016, 53% of the people who inject psychoactive drugs tested in the Unlinked Anonymous Monitoring (UAM) survey in England, Wales and Northern Ireland tested positive for this infection; prevalence among people who inject drugs (PWID) tested as part of the Needle Exchange Surveillance Initiative (NESI) in Scotland in 2015/16 was 58%. These were the highest prevalence values seen in the past decade. Hepatitis B prevalence among UAM participants was 14% in 2016, while HIV prevalence among those taking part in the UAM in 2016 was estimated to be 0.85%, the lowest value seen in the past decade. Prevalence of BBVs is lower among those who inject image and performance enhancing drugs (IPEDs). The UK has a targeted hepatitis B vaccination programme focused on at-risk groups, including PWID. Seventy-two per cent of UAM participants in 2016 self-reported hepatitis B vaccination uptake. In Scotland, 81% of those participating in the 2015/16 NESI survey reported uptake of the hepatitis B vaccine.

Injection of crack cocaine has increased in recent years among the PWID surveyed as part of the UAM, with 53% of current injectors, ie those who had injected during the preceding four weeks, reporting crack injection, compared to 35% in 2006. Crack cocaine injection also increased among those who first injected during the preceding three years, with 50% of these individuals who were current injectors reporting crack injection in 2016, compared to 28% in 2006. Thirty-six per cent of PWID participating in the UAM in 2016 reported experiencing an abscess, sore or open wound at an injection site during the preceding year, showing a continued increase from the figures reported between 2011 and 2013 (28% to 29%).

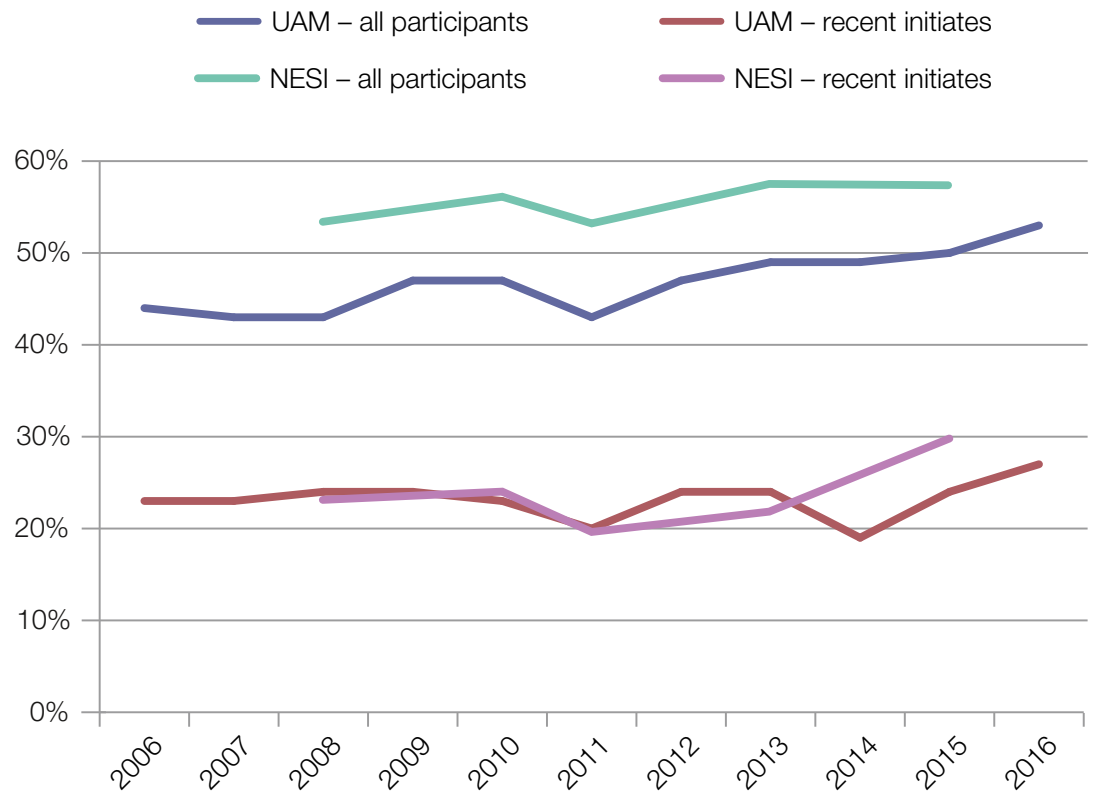
7.2 Blood-borne viral infections among people who inject psychoactive drugs

7.2.1 Hepatitis C

PWID are the group most affected by hepatitis C in the UK: around 90% of the hepatitis C infections diagnosed in the UK are thought to have been acquired through injecting drug use. Across the UK, approximately 13,500 positive test results for hepatitis C were reported during 2016. Although data on exposure is often incomplete or missing, extrapolation from the results where information is available suggests that in 2016 approximately 12,400 positive test results were from PWID (Public Health England et al., 2017).

Prevalence of hepatitis C infection among PWID remains relatively high. In 2016 the overall prevalence of antibodies to hepatitis C (anti-HCV) among the current and former PWID participating in the UAM survey was 53% (Public Health England, 2017e). This was the highest prevalence seen in the past decade (see Figure 7.1). At 54%, anti-HCV prevalence in England was the highest of the three countries participating in the UAM, with prevalence in Wales at 52% and Northern Ireland at 22% (see accompanying table 5.1). While hepatitis C prevalence among the participants in the UAM survey has remained relatively stable over time, in Wales there has been an increase from 20% recorded in 2006. There were regional variations in England, from 38% in the North East region to 67% in the North West and South West regions. In Scotland, the estimated anti-HCV prevalence among current and former PWID taking part in the NESI survey was 58% in 2015/16. This has increased from the 54% of participants that tested positive in 2008/09 (see Figure 7.1) (Health Protection Scotland, 2017b).

Figure 7.1: Prevalence of anti-HCV among all participants and recent initiates in the Unlinked Anonymous Monitoring survey in England, Wales and Northern Ireland, 2006 to 2016, and the Needle Exchange Surveillance Initiative† in Scotland, 2008/09 to 2015/16*



*A recent initiate is someone who first injected during the preceding three years

†NESI data for 2008/09 is represented in 2008; 2011/12 is represented in 2011; 2013/14 is represented in 2013; and 2015/16 is represented in 2015

Source: (Health Protection Scotland, 2017b; Public Health England, 2017e)

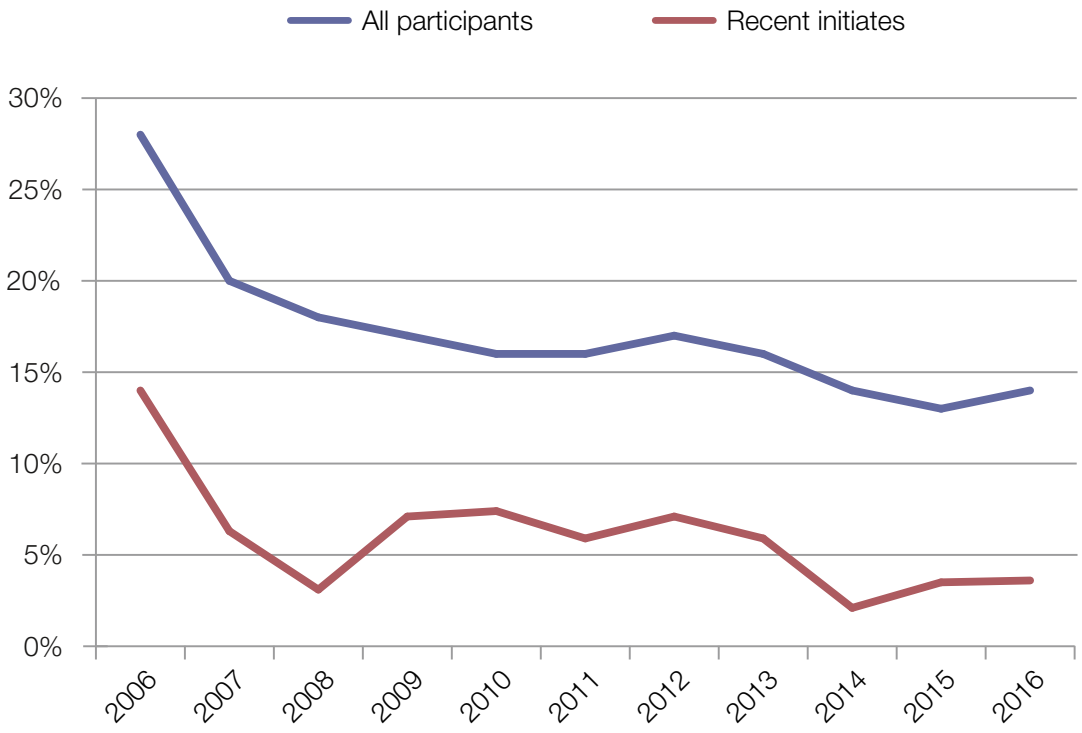
The level of hepatitis C transmission among PWID in the UK appears to have changed little in recent years, as anti-HCV prevalence among recent initiates (that is, those who had started injecting in the past three years) has been fairly stable. Among this group participating in the UAM survey, prevalence was 27% in 2016, not markedly different from the 23% found in 2006. In Scotland, anti-HCV prevalence among recent initiates has increased from 20% in 2011/12 to 30% in 2015/16 (Health Protection Scotland, 2017b). One-fifth (21%) of those in Scotland who started injecting in the past year tested positive for anti-HCV in 2015/16.

Incidence of hepatitis C infection among PWID in 2016 was estimated to be 16 infections per 100 person years (py) of exposure in England, Wales and Northern Ireland (Public Health England et al., 2017). The incidence of hepatitis C infections among PWID in Scotland was estimated to be 11.4 infections per 100 py of exposure during 2015/16 (Health Protection Scotland, 2017b).

7.2.2 Hepatitis B

In 2016, 14% of the current and former PWID who took part in the UAM survey had antibodies to hepatitis B core antigen (anti-HBc), a marker of current or previous hepatitis B infection (Public Health England, 2017e). This prevalence has remained relatively stable in recent years, but is lower than the level seen ten years ago when prevalence was 28% (see Figure 7.2). The prevalence of anti-HBc varied by country: prevalence was highest in England, at 15%; in Wales, prevalence was 13%; and prevalence was lowest in Northern Ireland, at 6.4% (see accompanying table 5.2). Prevalence across the three countries has decreased since 2006 (see Figure 7.2); this may reflect the impact of increased uptake of the hepatitis B vaccine among injecting drug users (see section 7.6.3). Anti-HBc prevalence was last reported for Scotland in the NESI results for 2013/14, when it was 9.0% (Health Protection Scotland, 2017b).

Figure 7.2: Prevalence of anti-HBc among all participants and recent initiates in the Unlinked Anonymous Monitoring survey in England, Wales and Northern Ireland, 2006 to 2016*



*A recent initiate is someone who first injected during the preceding three years

Source: (Public Health England, 2017e)

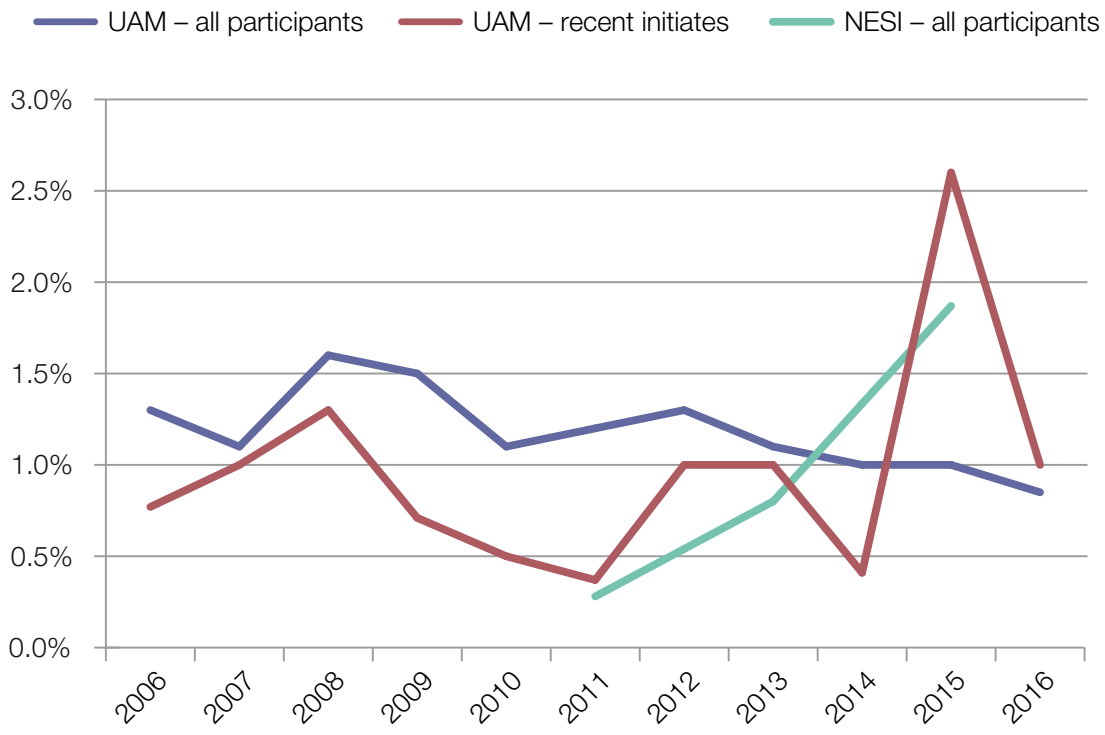
The samples collected by the UAM survey of PWID during 2016 that had anti-HBc detected were also tested for hepatitis B surface antigen (HBsAg), a marker of current infection. In 2016, of the samples from the UAM survey of PWID with anti-HBc, 3.0% had HBsAg detected, (Public Health England, 2017e). This represents 0.43% of all the PWID surveyed for hepatitis B prevalence in England, Wales and Northern Ireland that year, suggesting that only around one in 200 people who have injected psychoactive drugs are currently living with hepatitis B infection. In Scotland in 2013/14, 11% of those testing positive for anti-HBc also tested positive for HBsAg, representing 0.95% of those participating in NESI that year (Health Protection Scotland, 2017b).

While hepatitis B remains rare among PWID, probably reflecting the impact of the increase in the uptake of the hepatitis B vaccine among this group, it is important that vaccine uptake is sustained, particularly in younger age groups (Public Health England et al., 2017).

7.2.3 HIV

The current prevalence of HIV among PWID is similar to that seen in recent years. Among the current and former PWID taking part in the UAM survey across England, Wales and Northern Ireland in 2016, the prevalence of HIV was 0.85% (Public Health England, 2017e). Between 2006 and 2015, prevalence varied between 1.0% and 1.6% (see Figure 7.3). In 2016 prevalence was 0.9% in England, 1.4% in Wales, and 0% in Northern Ireland (see accompanying table 5.3). In Scotland, among the PWID attending needle and syringe programmes (NSP) participating in the NESI survey during 2015/16, 1.9% were found to be HIV antibody positive (Health Protection Scotland, 2017b). HIV testing was only undertaken for those individuals participating from NHS Greater Glasgow & Clyde and NHS Lothian health boards; prevalence was 2.5% and 0.6% in these areas, respectively. Prevalence in the NHS Greater Glasgow & Clyde health board may have been affected by the recent outbreak of HIV seen in Glasgow (see section 7.8.2).

Figure 7.3: Prevalence of antibodies to HIV among all participants and recent initiates in the Unlinked Anonymous Monitoring survey in England, Wales and Northern Ireland, 2006 to 2016, and in the Needle Exchange Surveillance Initiative,† 2011/12 to 2015/16‡*



*A recent initiate is someone who first injected during the preceding three years

†Data on anti-HIV prevalence from the NESI comes from NHS Greater Glasgow & Clyde and NHS Lothian health boards only

‡NESI data for 2011/12 is represented in 2011; 2013/14 is represented in 2013; and 2015/16 is represented in 2015

Source: (Health Protection Scotland, 2017b; Public Health England, 2017e)

HIV prevalence among recent initiates to injecting drug use is an indicator of recent HIV transmission. The prevalence among the recent initiates participating in the UAM survey in England, Wales and Northern Ireland was 1.0% in 2016 (Public Health England, 2017e). Although lower than that seen in 2015 (2.6%), this prevalence is similar to that seen in previous years (see Figure 7.3). The higher HIV prevalence in new initiates in 2015 was due to an increase in the number of men who reported having sex with men living with HIV in this group. In 2015, all of those with HIV in this group were men who reported having sex with men during the preceding year. The elevated prevalence of HIV in this group during 2015 therefore most probably reflected the increase in injecting drug use that had recently been seen among some groups of men who have sex with men (MSM), many of whom are HIV positive, rather than indicating an increase in the level of HIV transmission among PWID overall. It should also be noted that the number of MSM among respondents to the UAM is small, therefore fluctuations in percentages are more likely.

There were 143 new HIV diagnoses associated with injecting drug use in the UK during 2016; this was slightly lower than the annual average of 168 new HIV diagnoses per year between 2006 and 2015. In Scotland there were 36 new HIV diagnoses in 2016. This is lower than in 2015 when there were 50 new diagnoses, when an on-going outbreak of HIV began among PWID in Glasgow, but higher than the average of 18 new diagnoses per year between 2006 and 2014 (Public Health England et al., 2017) (see section 7.8.2).

Limited outbreaks of HIV continue among PWID in the rest of the UK. There was an outbreak of HIV in south west England in 2016, with 11 new cases of HIV of a specific subtype (CRF 11) diagnosed among PWID. Prior to this, only sporadic cases of HIV CRF 11 had been identified in the UK.

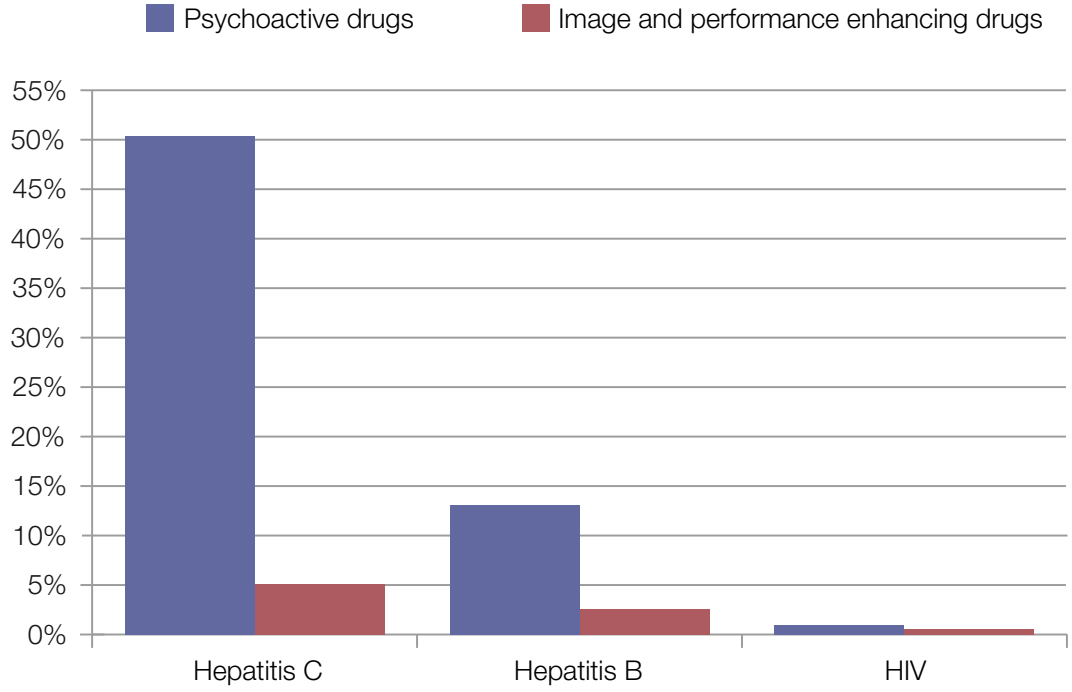
7.3 Blood-borne viral infections amongst people who inject image and performance enhancing drugs

The second UAM survey of people who inject IPEDs was undertaken in 2014/15 (Public Health England, 2016c). The 354 participants from across England and Wales were principally recruited through NSP over an 18 month recruitment period.[83] Of the participants in 2014/15: 0.56% tested positive for HIV (compared with 1.0% in PWID using psychoactive drugs in 2015); 2.5% were positive for anti-HBc (compared with 13% in those PWID using psychoactive drugs in 2015); and 5.1% had anti-HCV (compared with 50% in those PWID using psychoactive drugs in 2015) (see Figure 7.4) (Public Health England, 2016b, 2016c).

In Scotland, among those surveyed attending NSP who had only injected IPEDs during the past six months, 11% had anti-HCV in 2015/16 (Public Health England, Health Protection Scotland, Public Health Wales, & Public Health Agency Northern Ireland, 2016). The prevalence of BBV infections amongst IPED injectors in Northern Ireland is currently not known.

83 An 18 month recruitment period was used, instead of the 12 months used in the main UAM survey of PWID, due to the cyclic nature of some of the forms of drug use among this target population

Figure 7.4: Prevalence of antibodies to HCV, HBc and HIV among all participants in the Unlinked Anonymous Monitoring survey in England, Wales and Northern Ireland, 2015, and the Unlinked Anonymous Monitoring survey of people who inject image and performance enhancing drugs in England and Wales, 2015/16



Source: (Public Health England, 2016c, 2017e)

7.4 Other drug-related infectious diseases

7.4.1 Tuberculosis

There were 5,664 cases of tuberculosis (TB) reported in England in 2016 (Public Health England, 2017n). Among the cases with known information on the four social risk factors monitored among TB cases in England: 4.3% (218/5,109) had either a history of, or currently had, a problem with drug use; 3.7% (187/5,118) of alcohol misuse; 4.0% (202/5,098) of homelessness; and 4.0% (200/4,948) of imprisonment. Just over eleven per cent (11.1%; 534/4,828) of TB cases in 2016 had at least one of these social risk factors, compared with 11.7% (581/4,950) of cases in 2015.

7.4.2 Injection site infections

In 2016, 36% of PWID participating in the UAM survey reported that they had experienced an abscess, sore or open wound at an injection site – all symptoms of injection site infection – during the preceding year (Public Health England, 2017e). This is an increase from 28%-29% reported between 2011 and 2013. The prevalence of these symptoms was particularly high among the under-25 year age group at 43%, more than double the proportion of under-25s reporting these symptoms in 2013 (20%). Among those participating in the NESI survey in Scotland in 2015/16, 17% reported that they had experienced a severe soft tissue infection, defined as an abscess or open wound at an injecting site, in the last year (Health Protection Scotland, 2017b).

Among the participants in the 2014/15 UAM sub-survey of people who inject IPEDs, 14% reported that they had ever experienced symptoms of injecting-site infection, with the highest proportion seen in the 25-34 age group (17%) (Public Health England, 2016c). This is

a slight decrease from 2012/13, when 16% reported ever experiencing symptoms, and the proportion of 25-34 year-olds reporting these symptoms was 22%.

7.4.3 Meticillin-sensitive and meticillin-resistant Staphylococcus aureus

Severe illnesses among PWID due to hygiene-related bacterial infections continue to occur, including those caused by *Staphylococcus aureus* and Group A streptococci. Data for 2016 from the mandatory enhanced surveillance of meticillin-sensitive *S. aureus* (MSSA) and meticillin-resistant *S. aureus* (MRSA) bacteraemias indicate that of those with risk factor information, 13% (324/2492) of the MSSA bacteraemias were associated with injecting drug use, as were 8.1% (22/272) of the MRSA bacteraemias. This represents an increase in the proportion of cases for which injecting drug use was indicated over the last six years, from 6.9% for MSSA and 1.6% for MRSA in 2011. These numbers do need to be considered with caution, however, as risk factor information is missing for a large proportion of MRSA and MSSA bacteraemias reported (Public Health England et al., 2017).

7.4.4 Group A streptococci

Indicators suggest that there has been a recent increase in invasive Group A streptococcal (iGAS) infections identified among homeless people and PWID. Clusters of infection have been noted in several parts of the country, including Brighton, Gloucestershire, Bristol, London and Bournemouth. These clusters were associated with history of homelessness and/or alcohol use. The cluster in Brighton involved an outbreak of an unusual type of *Streptococcus pyogenes* Group A streptococcus (GAS) type *emm66*: 65 *emm66* infections were identified, of which 42 were associated with injecting drugs.

In 2016 there were 67 isolates of iGAS for which injecting drug use was indicated; this is 3.7% of all invasive isolates (67/1817). Sixteen isolates were part of the on-going outbreak of GAS type emm66 in England and Wales. Excluding these cases, there were 49 isolates for which injecting drug use was indicated (2.6% of all invasive isolates), more than double the number of isolates from PWID reported in 2015 (n=20; 1.2%) (Public Health England et al., 2017).

Although the increases in MRSA/MSSA and Group A streptococci could be an artefact of enhanced clinical awareness and cases ascertainment, there are other indicators of an increase in bacterial infections among PWID. Lewer et al investigated hospital episode statistics data from 1997 to 2016 for patients aged 15-55 for injecting-related problems or invasive infections related to injecting. They found that the total number of injecting-related admissions increased each year in all age groups from 2012/13 to 2015/16, with the largest relative increase occurring in the 45–55-year-old age group (an 18% increase per year) (Lewer, Harris, & Hope, 2017).

7.4.5 Infections due to spore-forming bacteria

Illnesses caused by the toxins produced by spore-forming bacteria, such as botulism, tetanus or anthrax, continue to cause problems among PWID. The spores produced by these bacteria are found in the environment, and may end up in drugs, such as heroin, through contamination. There were seven cases of wound botulism in 2016; four confirmed and three probable cases. Two cases were identified in the same region, but no links were identified between them, or between any of the other cases. During 2016, there was one case of clinically confirmed tetanus, and no cases of anthrax, reported among PWID in the UK (Public Health England et al., 2017).

7.5 Infection-related risk behaviours

The extent and patterns of infections over time reflect changing patterns of risk. Risk will be impacted by the extent of service provision, particularly the provision and uptake of harm reduction and health protection interventions such as NSP, opioid substitution treatment (OST), vaccination, and diagnostic testing services. The provision of these services is widespread across the UK, and provision and uptake have both improved over the last decade (see section 7.6).

7.5.1 Sharing of injecting equipment

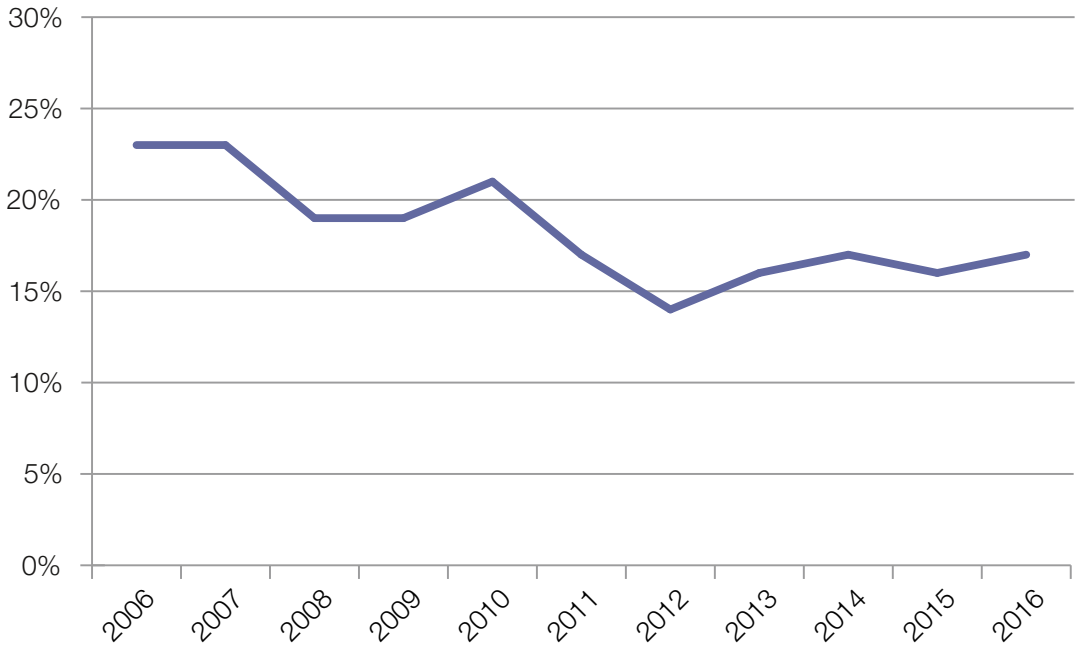
People who inject psychoactive drugs

The level of direct sharing of needles and syringes among current injectors reported by participants in the UAM survey in England, Wales and Northern Ireland has decreased from 28% in 2005 to 17% in 2016 (Public Health England, 2016b, 2017e) (see Figure 7.5). Over the last ten years, direct sharing levels were higher among women than men: in 2016, 23% of female PWID reported direct sharing, compared with 15% of males. Direct sharing was found to vary across England (18%), Wales (11%) and Northern Ireland (8.3%).

Sharing of any of the injecting equipment asked about in the UAM survey (ie needles, syringes, mixing containers, or filters; direct and indirect sharing) was reported by 39% of current injectors in 2016, an increase from 36% the previous year (Public Health England, 2017e). Sharing of any of this equipment was reported by 40% of the participants in England, by 36% in Wales, and by 13% in Northern Ireland.

In Scotland, seven per cent of those participating in the NESI who had injected within the past six months reported using a needle or syringe that had been previously used by someone else; 21% reported using other injecting equipment that had previously been used by another person (Health Protection Scotland, 2017b). Both proportions are less than half the percentages seen in 2008/09 (15% and 47%, respectively). Reported personal reuse of needles and syringes has gradually increased from 45% in 2011/12 to 54% in 2015/16, reversing the decrease previously seen (from 63% in 2008/09).

Figure 7.5: Percentage of current injectors participating in the Unlinked Anonymous Monitoring survey reporting needle and syringe sharing in England, Wales and Northern Ireland, 2006 to 2016*



*Those reporting injecting in the four weeks preceding survey participation

Source: (Public Health England, 2016b, 2017e)

People who inject image and performance enhancing drugs

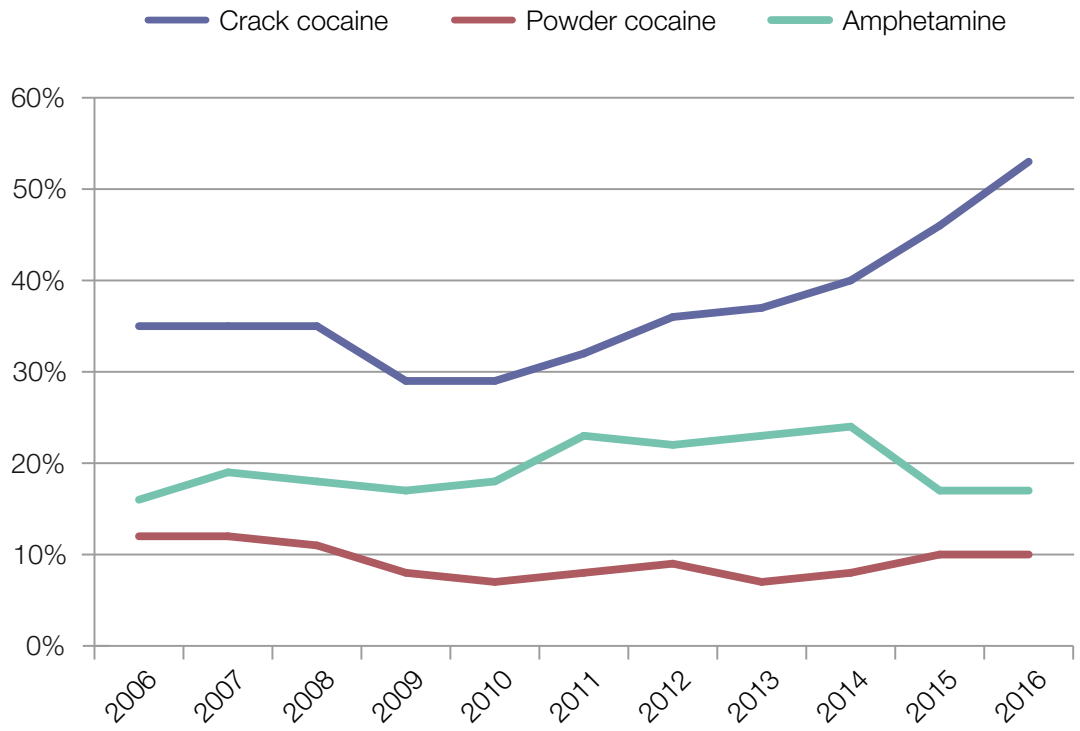
Among the participants in the 2014/15 UAM sub-survey of people who inject IPEDs, 13% reported ever sharing any injecting equipment (needle, syringe or vial) (Public Health England, 2016c).

7.5.2 Injection of stimulants

There have been concerns in recent years about increased injection of stimulants including an increase in crack cocaine injection. As their effects are short-lived, stimulants may be injected more frequently than opioids, and compulsive re-dosing has been reported (Hope et al., 2016; Public Health England et al., 2015).

Injection of crack cocaine appears to have increased in England and Wales over the past seven years. Among the PWID participating in the UAM survey in 2016, 53% of those who had injected during the preceding four weeks reported injecting crack cocaine, compared to 30% in 2010 (see Figure 7.6). This proportion was highest in England (55%), with multiple regions of England (East of England, London, South East, South West and East Midlands) seeing a significant increase since 2006. The percentage of UAM participants in Wales that report injecting crack cocaine has also markedly increased, from 8.6% in 2010 to 37% in 2016. None of the Northern Irish UAM participants reporting injecting crack cocaine in 2016. In comparison, over the past decade there has been no significant change in the injection of powder cocaine (10% in 2016 versus 12% in 2006) or amphetamine (17% in 2016 versus 16% in 2006) among those who had injected in the preceding four weeks. In Scotland, powder cocaine is more commonly injected than crack cocaine: results from the 2015/16 NESI showed that 13% of those that had injected in the past six months had injected powder cocaine, compared to three per cent who had injected crack cocaine (Health Protection Scotland, 2017b).

Figure 7.6: Percentage of current injectors participating in the Unlinked Anonymous Monitoring survey in England, Wales and Northern Ireland that had injected crack cocaine, powder cocaine or amphetamine in the past four weeks, 2006 to 2016*



*Those reporting injecting in the four weeks preceding survey participation

Source: (Public Health England, 2017e)

Since their appearance on the market in the late 2000s and early 2010s, new psychoactive substances (NPS) have been injected as well as inhaled or ingested. There have previously been concerns over the increase in the number of PWID reporting injecting NPS; however, it appears this number is now reducing. In England, Wales and Northern Ireland, 4.4% of those surveyed as part of the UAM survey in 2016 reported that they had injected mephedrone at some point during the preceding year, which was a decrease from previous years (9.0% in 2014, 8.2% in 2015) (Public Health England et al., 2017). Injection of NPS was more common in the NESI: in 2015/16, 10% of those who had injected in the past six months had injected 'legal highs' (Health Protection Scotland, 2017b).

Injection of stimulants has previously been associated with an increase in risky injection practices. In the UAM survey results covering 2015, one-third (32%) of those currently injecting mephedrone reported sharing needles or syringes previously used by someone else, whereas 18% of those who had not injected mephedrone reported direct sharing of needles or syringes (Public Health England et al., 2016).

7.5.3 Condom use and sexual behaviour in people who inject drugs

In 2016, just under two-thirds (64%) of the PWID participating in the UAM survey reported having anal or vaginal sex during the preceding year. This level has been steadily dropping since 2010, when 75% of respondents reported having anal or vaginal sex during the preceding year (Public Health England, 2017e). Of those who had sex in the last year, 37% reported having had two or more sexual partners during that time, and of these individuals, 23% reported always using a condom during sex. This proportion has slowly increased from 17% in 2012; however, the data suggests that increased efforts are required to improve the use of condoms among PWID.

Those who inject IPEDs appear to be more sexually active than those injecting psychoactive drugs, as among the participants in the 2014/15 UAM sub-survey of people who inject IPEDs, 92% reported having anal or vaginal sex during the preceding year (Public Health England, 2016c). Just over half (51%) of those reporting having sex reported having two or more sexual partners during the year. Of these participants, 17% reported always using a condom, a smaller proportion than in the main UAM survey of PWID.

Chemsex

There are on-going concerns about the injection of methamphetamine and mephedrone among some sub-groups of MSM, many of whom are HIV positive. These drugs are typically being used by these men during sex in a practice known as chemsex, with injecting equipment often shared while condoms are not always used. Although the scale of this behaviour remains unclear, specialist lesbian, gay, bisexual and transgender drug services have seen an increase in the number of MSM who report injecting methamphetamine and mephedrone in recent years, and the behaviour is now evident among MSM accessing general drug services (Glass, Hope, Tanner, & Desai, 2017). The use and injection of these drugs has also been reported to be a factor in the increased transmission of a number of sexually transmitted infections (Bourne et al., 2014; Kirby & Thornber-Dunwell, 2013).

7.6 Prevention and control of drug-related infectious diseases: harm reduction services

7.6.1 Needle and syringe programmes

NSP are provided throughout the UK in a variety of settings, principally through pharmacies and specialist drug treatment services. Data on needle and syringe provision in Scotland, Wales and Northern Ireland is available (see below). There are a small number of mobile syringe exchanges, usually attached to a local treatment provider. In Wales there is a single vending machine which can be used to obtain syringes, and in England the first needle exchange vending machine in the UK, allowing the disposal of used needles and dispensing new injecting equipment, was introduced in January 2018.[84]

NSP aim to reduce harm by offering advice on safer injecting practice, helping PWID to access treatment and signposting them to other relevant health services such as BBV testing, sexual health services, mental health services and welfare and advocacy services. They may also provide foil to drug users as a means of encouraging them to switch to non-injecting methods, as well as engaging them in structured treatment. NSP are commissioned locally and are monitored by local authorities to ensure that they comply with clinical guidelines.85 NSP services are in some cases available in targeted environments to meet the needs of people who use IPEDs, for example outreach services in gyms.

Harm reduction initiatives providing NSP also exist in areas outside of specialist drug services; for example, sexual health clinics may offer advice aimed at drug users. In addition, a number of specialist services exist for the needs of those who are engaging in chemsex.

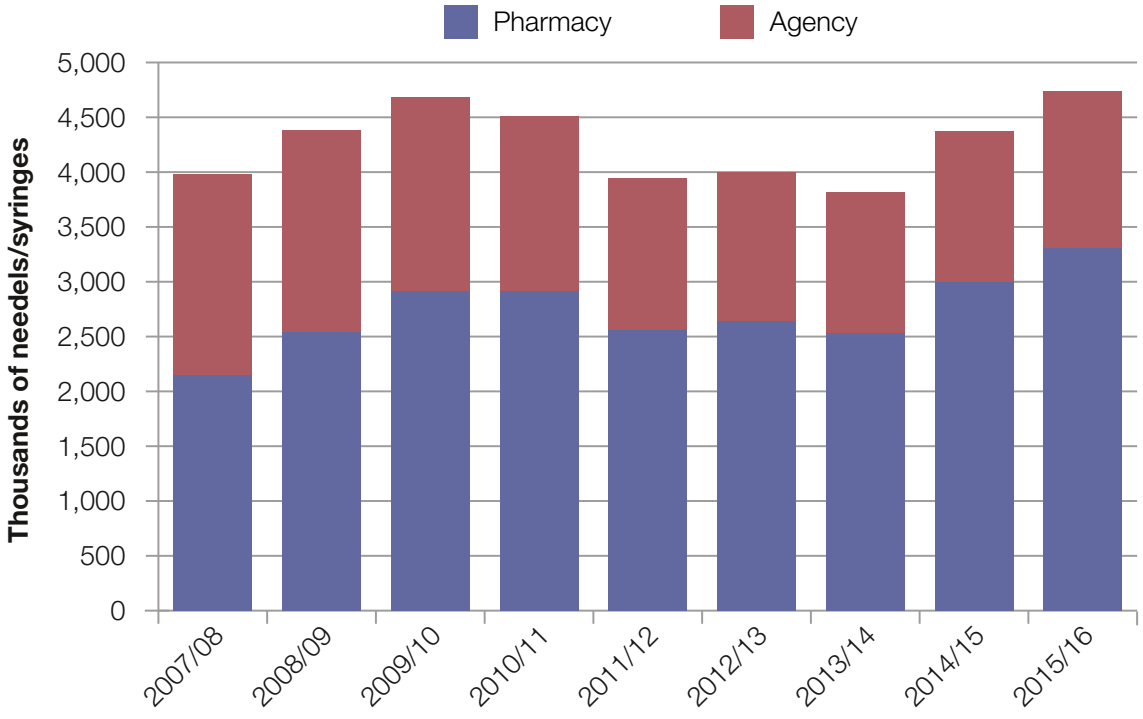
84 See: https://www.addaction.org.uk/news/addaction-launches-uk%E2%80%99s-first-pharmacy-based-needle-exchange-dispenser

85 See: https://www.nice.org.uk/guidance/ph52

Scotland

In Scotland, there were 287 injection equipment provider outlets reporting to be operating in 2015/16, of which 219 (76%) were pharmacy-based (Information Services Division, 2017a). This represented an increase from 188 outlets in 2004/05, and was a similar number to 2014/15 (288 outlets). Over the course of 2015/16, 4.7 million needles/syringes were reported to have been distributed to PWID in Scotland, based on data collected from 97% (278/287) of the injection equipment provider outlets. This is similar to the number of needles/syringes reported to have been distributed between 2007/08 and 2014/15, which ranged from 3.8 million to 4.7 million (see Figure 7.7 and accompanying table 5.4). The number of injecting paraphernalia items (ie items other than needles and syringes) distributed to PWID has increased in recent years, with notable rises in the provision of filters and spoons/cookers between 2008/09 and 2009/10, and more recently in the provision of sterile water between 2012/13 and 2013/14. In 2015/16, the items distributed included: 3.5 million filters; 3.4 million spoons/cookers; 1.6 million vials of sterile water; and 4.5 million wipes/swabs.

Figure 7.7: Number of needles and syringes distributed in Scotland, by outlet type, 2007/08 to 2015/16



Source: (Information Services Division, 2017a)

Wales

The provision of NSP and other harm reduction services in Wales is monitored using the Harm Reduction Database (HRD). In 2016/17 the HRD was active in 42 statutory and voluntary sector NSP sites across Wales, and 215 community pharmacies providing NSP services. Data from the HRD indicates that 9,717 unique individuals accessed specialist NSP services and 18,530 unique individuals accessed community pharmacy NSP services from April 2016 to March 2017 (this may include some crossover, as some individuals may have accessed both specialist and community pharmacy NSP services). Over this time period, a total of 3,100,009 syringes were distributed: 57% (n=1,770,451) of syringes were distributed through pharmacy-based NSP, while specialist agencies distributed 43% (n=1,329,558) (see accompanying table 5.4).

Northern Ireland

In Northern Ireland, NSP were available at 20 sites (19 pharmacies and one community addiction team service) in five trust areas in 2017, as well as from two needle exchange outreach services (personal communication – Public Health Agency). Pharmacies issued 35,573 packs during 2016/17, a slight decrease from 2015/16 (n=36,145), but higher than the number issued in 2014/15 (n=34,258). In 2016/17, 29,283 client contacts took place, predominantly through pharmacy-based NSP. Of the 28,500 contacts where it was recorded what the needles would be used for, 63% were for opioids, 32% were for steroids, 6.1% were for tanning products and 0.3% were for amphetamines (Health and Social Care Board & Public Health Agency, 2017a).[86] The most recent data on the number of needles/syringes distributed within Northern Ireland covers 2015/16; in this year, a total of 309,570 needles/syringes were distributed, with the vast majority (n=306,125) being issued by pharmacy-based NSP (see accompanying table 5.4).

7.6.2 Hepatitis C diagnosis and treatment

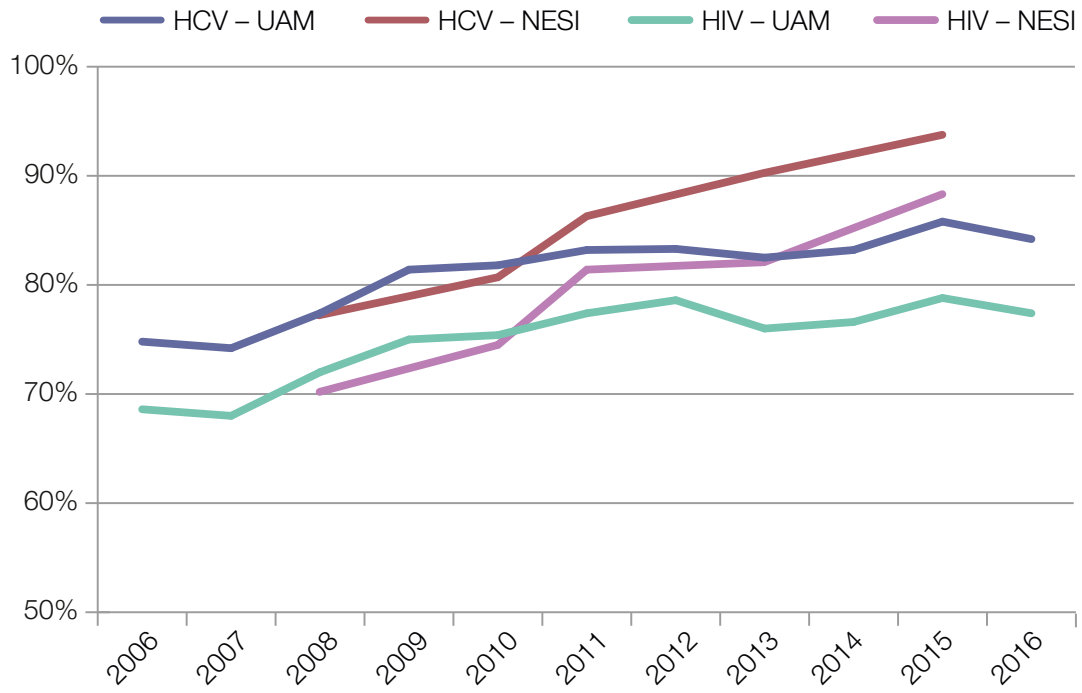
Hepatitis C prevention strategies primarily focus on injecting drug use, as this is at present the most important risk factor for acquisition of the virus in the UK. Reducing the number of individuals who begin injecting drugs, encouraging injectors to stop injecting, reducing risky behaviour (such as sharing needles and syringes) in those who continue to inject, and the early diagnosis and treatment of those who become infected with hepatitis C are all components of the prevention programme.

Data from the UAM survey of PWID shows a significant increase over the past decade in the self-reported uptake of voluntary confidential testing (VCT) for HCV among survey participants. The proportion of survey participants ever tested rose from 67% in 2004 to 82% in 2010; this proportion has remained stable since, and in 2016 was 84% (see Figure 7.8) (Public Health England, 2017e). This stabilisation may suggest that there is saturation among the pool of easy-to-access individuals and/or a reduction in awareness-raising activity. Fifty-two per cent of the participants who answered the questions on HCV VCT in 2016 reported that they were aware of their hepatitis C infection. This indicates that around half of the hepatitis C infections in this population remain undiagnosed.

In Scotland, among those giving a response in the NESI survey in 2015/16, 94% reported ever being tested for HCV, an increase from 90% in 2013/14, and 77% in 2008/09 (see Figure 7.8) (Health Protection Scotland, 2017b). Excluding those who reported a previous hepatitis C diagnosis (prior to 12 months ago), the percentage of respondents who had been tested for hepatitis C during the last year has been steadily increasing and was 55% in 2015/16, compared to 40% in 2008/09.

86 Values will not add up to 100% due to some clients using multiple drug types

*Figure 7.8: Percentage of participants reporting having ever undertaken voluntary confidential testing for hepatitis C or HIV in the Unlinked Anonymous Monitoring survey 2006 to 2016, and the Needle Exchange Surveillance Initiative 2008/09 to 2015/16**



*NESI data for 2008/09 is represented in 2008; 2011/12 is represented in 2011; 2013/14 is represented in 2013; and 2015/16 is represented in 2015

Source: (Health Protection Scotland, 2017b; Public Health England, 2017e)

Among the participants in the 2014/15 UAM sub-survey of people who inject IPEDs, 41% reported ever having a VCT for HCV, an increase from 32% in 2014 (Public Health England, 2016c). The reported level of the uptake of VCT for HCV in this group was much lower than that reported among participants in the main survey of people who inject psychoactive drugs in 2014 (83%) (Public Health England, 2016b).

Mathematical modelling work indicates that successfully treating hepatitis C infections among PWID (Martin et al., 2013), alongside provision of NSP and drug treatment services, could reduce transmission of hepatitis C (Public Health England, 2017f). Among the participants from the UAM survey of PWID in England who had received a positive diagnosis and were aware of their hepatitis C status, 64% reported that they had seen a specialist doctor or nurse about their infection, and 25% reported being given any medication related to their HCV infection (Public Health England, 2017f). Similarly, in the 2015/16 NESI, 28% of those who self-reported that they were HCV positive (or who self-reported cleared after therapy) had ever received drug therapy for HCV (Health Protection Scotland, 2017b). Just over one-third (36%) of these individuals had received treatment in the past year.

Provisional estimates suggest that number of people in the general population initiating HCV treatment in the UK between 2009 and 2014 remained relatively stable at around 6,400 initiations per year; however, provisional estimates for 2016/17 suggest that significantly more people (around 12,060 in total) accessed treatment in this year (Public Health England, 2017g).

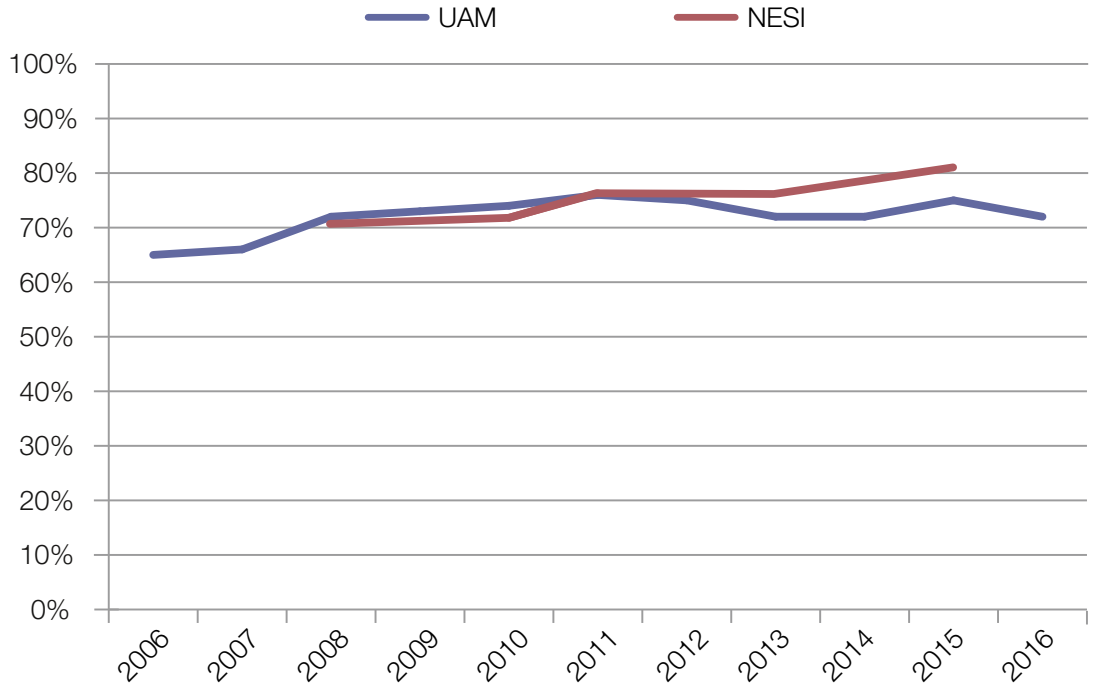
7.6.3 Hepatitis B vaccination

As hepatitis B is a vaccine-preventable infection, the UK has a targeted vaccination programme focused on the population groups most at risk, including PWID.

The proportion of PWID participating in the UAM survey who reported having taken up an offer of the hepatitis B vaccination has increased markedly over time, rising from 56% in 2004 to 76% in 2011. Uptake has decreased slightly in the following years, and in 2016 was 72% (see Figure 7.9) (Public Health England, 2017e). Uptake of hepatitis B vaccination was 71% in England, 67% in Wales, and 82% in Northern Ireland. In Scotland, among those participating in the NESI survey in 2015/16 that gave a response to the question, 81% reported receiving at least one dose of the hepatitis B vaccine, with 67% of respondents having received at least three doses (Health Protection Scotland, 2017b).

The level for uptake of the hepatitis B vaccination was lower among the participants of the 2014/15 sub-survey of people who inject IPEDs, with 38% of those injecting IPEDs reporting uptake of the vaccine (Public Health England, 2016c).

Figure 7.9: Uptake of hepatitis B vaccination among participants in the Unlinked Anonymous Monitoring survey in England, Wales and Northern Ireland, 2006 to 2016, and the Needle Exchange Surveillance Initiative, 2008/09 to 2015/16†*



*UAM data is for those respondents self-reporting uptake of the offer of an HBV vaccine; NESI data is for those responding to the question that reported having had at least one dose of the HBV vaccine

†NESI data for 2008/09 is represented in 2008; 2011/12 is represented in 2011; 2013/14 is represented in 2013; and 2015/16 is represented in 2015

Source: (Health Protection Scotland, 2017b; Public Health England, 2017e)

7.6.4 HIV diagnosis and treatment

In 2016, 77% of PWID in England, Wales and Northern Ireland participating in the UAM survey reported ever having a test for HIV, similar to the uptake reported for 2015 (79%), and an increase from the 69% seen in 2006 (see Figure 7.8) (Public Health England, 2017e). The increase in

uptake of VCT for HIV was particularly marked for those aged under 25, from 57% in 2006 to 74% in 2016. Among those who first injected in the preceding three years, 62% reported ever having had a test for HIV, a small decrease from 68% in 2015. In 2016, of the participants in the UAM survey who had antibodies to HIV, 95% reported awareness of their infection.

In Scotland, 88% of those giving a response in the 2015/16 NESI survey reported having ever had been tested for HIV. This figure has increased in every NESI, from 70% in 2008/9 (see Figure 7.8) (Health Protection Scotland, 2017b).

Among the participants in the 2014/15 sub-survey of people who inject IPEDs, 47% reported ever having a VCT for HIV; as with the figures for HCV VCT, this was markedly lower than self-reported levels in the main UAM survey of people who inject psychoactive drugs in 2014 (77%) (Public Health England, 2016c).

The number of HIV-infected individuals seen for HIV treatment and care in the UK who had acquired their infection through injecting has increased over the past decade, with 1,869 cases seen in 2016 (Public Health England et al., 2017). Of these, 423 had CD4 counts of 350 cells/mm^3 or less (the recommended level to start anti-retroviral therapy prior to 2015). Among those seen for HIV treatment and care with CD4 counts of 350 or less in 2016, 94% of those who had acquired their infection through injecting were on anti-retroviral therapy; this is similar to the level found in other groups. Following revision to the British HIV Association guidelines in 2015,[87] anti-retroviral treatment is now recommended for all those with HIV, irrespective of CD4 count. Although the majority of PWID living with HIV in the UK are aware of their infection, and most of those who are aware are accessing HIV treatment and care services late diagnoses remain a problem (Public Health England, 2017m). In 2016, 51% of the HIV diagnoses among people who had acquired their infection through injecting drugs were made at a late stage of HIV infection. This compares to 42% of the HIV diagnoses overall, for all the risk groups combined (Public Health England et al., 2017).

7.7 Drug testing at events

7.7.1 The Loop

The Loop[88] is a not-for-profit Community Interest Company that provides harm reduction and welfare services, and tests drugs seized on site and from amnesty bins in nightclubs and music festivals. In 2016, they piloted a drug testing service at two UK music festivals whereby attendees could take samples to be tested and find out what they contained; this front-of-house testing service was extended to three festivals in 2017.

7.7.2 Welsh Emerging Drugs & Identification of Novel Substances Project

WEDINOS[89] is a harm reduction service that collects and tests unknown/unidentified drugs. Individuals can mail samples for testing and the results are posted online. The website publishes information on the substance the individual intended to purchase as well as the actual contents of the sample.

87 See: http://www.bhiva.org/documents/Guidelines/Treatment/2015/2015-treatment-guidelines.pdf

88 See: http://wearetheloop.co.uk/

89 See: http://www.wedinos.org/resources/downloads/MDMA-1.pdf

7.8 New developments

7.8.1 Acute hepatitis C outbreak in Northern Ireland

An outbreak of acute hepatitis C was detected among PWID in Northern Ireland during 2016, after screening of PWID by the homeless nursing service diagnosed three cases of acute infection. The injecting networks of the individuals were identified and targeted for harm reduction education and screening, which identified that those most at risk of infection were predominantly injecting heroin and sharing injecting equipment, despite the availability of clean injecting packs.

Enhanced testing is on-going, mainly by the homeless nursing team, as more people at risk of acquiring infection are identified. A total of 40 RNA positive infections had been identified as of November 2017. Enhanced screening has identified new users, enabling referral for hepatitis C treatment and drug addiction services (Public Health England et al., 2017).

7.8.2 HIV outbreak in Glasgow

During 2015, there was a substantial increase in new cases of HIV among PWID in Glasgow. In total, 44 people were diagnosed in just one year – more than four times the number seen in previous years. In addition, 30 cases were diagnosed among PWID in Glasgow in 2016. The outbreak is on-going, with a further 21 people diagnosed as of June 2017 (Health Protection Scotland, 2017a). During early interviews with those affected by the outbreak, 83% reported injecting drugs in public places, especially in and around Glasgow city centre. This outbreak has shown that despite efforts to reduce drug-related harm, people who inject drugs in Glasgow continue to be at very high risk of ill-health and death. As a result, NHS Greater Glasgow & Clyde and Glasgow City ADP have conducted a health needs assessment, and are currently progressing the recommendations of this report through the local health and social care partnership (NHS Greater Glasgow and Clyde, 2016).

7.8.3 Safer drug consumption facility

In response to the outbreak of HIV in Glasgow (see section 7.8.2), Glasgow City Integration Joint Board (IJB) approved a draft business case from the Health and Social Care Partnership proposing the development of a co-located safer drug consumption facility and heroin assisted treatment service in February 2017.[90] In June 2017 Glasgow City IJB was updated of progress towards this development, which included: a proposed location; operational parameters and principles; and evaluation, legal and financial frameworks (Glasgow City Integration Joint Board, 2017). However, the legal status of the site with regard to its use as a drug consumption facility was deemed by the Lord Advocate to be the responsibility of the Home Office and (by the end of 2017) the proposal for the facility had not been approved.

7.8.4 Low dead space syringes

Investigation of the Glasgow HIV outbreak (see section 7.8.2) discovered that the majority of the cases had accessed 2 millilitre (ml) syringes from local NSP, rather than the 1 ml low dead space syringes (LDSS) also available. Two millilitre syringes were found to have a higher risk of spreading BBV, therefore the incident management team worked with their supplier to design a new 2 ml LDSS compatible with all needles, regardless of manufacturer (McAuley, Campbell,

90 See: https://glasgowcity.hscp.scot/meeting/15-february-2017

Milosevic, Hunter, & Goldberg, 2017). In the first six months following their introduction in April 2016, almost 300,000 LDSS were distributed in Glasgow and, as a result of a national procurement contract for NSP, the newly developed 2 ml LDSS are now distributed throughout Scotland.

7.8.5 Report Illicit Drug Reaction system

One major cause for concern with the recent emergence of NPS is the potential physical and mental health problems that these substances may cause, both acutely and with long-term use, which may only be seen sporadically by individual healthcare workers, and so not commonly reported. To address this, PHE in collaboration with the Medicines and Healthcare products Regulatory Agency (MHRA) are piloting the Report Illicit Drug Reaction (RIDR) system.

Based on the MHRA's Yellow Card scheme, this online, UK-wide system collects information submitted by healthcare professionals regarding adverse reactions suffered by individuals who have taken illicit drugs. The system is intended to be used by professionals from a wide range of backgrounds, such as emergency medical staff, sexual health professionals, and healthcare workers in prisons, who may come into contact with those who have used NPS. The data is analysed to detect signals indicating potential health harms associated with particular substances, and reports of the latest data are made available to view on the RIDR website.[91]

91 See: https://report-illicit-drug-reaction.phe.gov.uk/

8 Drug laws and offences

8.1 Introduction

The *Misuse of Drugs Act 1971* (Her Majesty's Government, 1971) is the principal legislation in the UK for the control and supply of psychoactive substances that are considered dangerous or otherwise harmful when misused. Under the act, drug use itself is not a crime but possession, production, supply, import and export are, and the associated penalties are related to the classification of the drug. Substances controlled by the act are put into one of three classes which determine the maximum penalties for each offence as defined under the act committed in relation to that drug. Controlled drugs are also placed in one of five schedules under *The Misuse of Drugs Regulations 2001* (Her Majesty's Government, 2001b), based on an assessment of their potential harms weighed up against the legitimate need for access. Schedules determine the circumstances in which drugs can be lawfully manufactured, possessed and distributed. A prison sentence is the most common outcome when found guilty at court of offences relating to supply, but a fine, community sentence or conditional discharge are the most common disposals for possession offences.

The *Psychoactive Substances Act 2016* (Her Majesty's Government, 2016c) is the other major piece of legislation covering the supply of drugs in the UK. This act came into force in 2016 with the intention of preventing the trade of new psychoactive substances (NPS), many of which were not covered by the *Misuse of Drugs Act 1971*. The *Psychoactive Substances Act 2016* is a blanket ban rather than being substance-specific, and makes it an offence to produce, supply, possess with intent to supply, import or export substances which cause a psychoactive effect in someone who consumes them (with a number of exemptions). Under this legislation, possession of a psychoactive substance is not in itself an offence unless within a custodial institution.

From 2005, the number of drug law offences in the UK increased to a peak in 2011, when there were 154,212 offences where the offender was found guilty or issued a caution. Since this point, the number of offences has decreased by one-quarter, and in 2015 was 115,377. As might be expected given its high prevalence relative to other drugs, cannabis is involved in the largest proportion of drug law offences.

8.2 Drugs legislation

8.21 Misuse of Drugs Act 1971

The *Misuse of Drugs Act 1971* (Her Majesty's Government, 1971) is the principal legislation in the UK for the control and supply of psychoactive substances that are considered dangerous or otherwise harmful when misused.[92] The act divides such substances into three classes (A, B and C) and sets maximum criminal penalties for illicit production, possession and supply in relation to each class (see section 8.3.1).

92 **Possession**: In the UK it is unlawful to possess any quantity of a controlled drug, unless the individual is in possession of an authorisation in the form of a licence (for example a prescription), or the person can prove that they were unaware that the substance was a controlled drug
Supply and possession with the intent of supply: Supply defined as the simple act of passing a controlled drug from one person to another. According to the law, it is irrelevant if the act is done for profit or not. The financial gain has influences only on the sentence given
Production: In the UK it is illegal to produce any controlled drug, unless the individual is in possession of an authorisation in the form of a licence. Production is defined as "manufacturing, cultivating or production by any other method"

Under the *Misuse of Drugs Act 1971*, police have special powers to stop, detain and search people on 'reasonable suspicion' that they are in possession of a controlled drug. Police may also enter and search premises with a warrant if there are reasonable grounds to suspect an offence against the act has been committed. A prison sentence is the most common outcome when found guilty at court of import/export and trafficking offences, but a fine, community sentence or conditional discharge are the most common disposals for possession offences (Ministry of Justice, 2017a). The range of possible penalties is covered in section 8.3.1.

8.2.2 The Misuse of Drugs Regulation 2001

Most drugs controlled under the act are also placed in one of the five schedules of *The Misuse of Drugs Regulations 2001* based on an assessment of their medicinal or therapeutic usefulness, the need for legitimate access, and potential harms when misused (Her Majesty's Government, 2001b).[93] The schedules determine the circumstances in which controlled substances can be lawfully manufactured, possessed and distributed. Those drugs deemed to have no therapeutic value are placed in Schedule 1, meaning that they cannot be prescribed. Research can be conducted on these substances but this requires a licence to be obtained from the Home Office. Drugs placed into the least restrictive schedule (Schedule 5) can be legally supplied and possessed without prescription.

8.2.3 Psychoactive Substances Act 2016

The *Psychoactive Substances Act 2016* (Her Majesty's Government, 2016c), which came into force on 26 May 2016, was introduced as a response to the increased use of NPS in the UK. Keeping pace with the NPS market presented a challenge using the existing legislation, as both the *Misuse of Drugs Act 1971* and temporary class drug orders (TCDOs) (see below) require drugs to be actively listed for them to be covered. The *Psychoactive Substances Act 2016*, however, controls all psychoactive substances[94] except for the following stated exemptions: drugs already controlled under the *Misuse of Drugs Act 1971*; medicinal products listed under *The Human Medicines Regulations 2012*; alcohol; nicotine and tobacco products; caffeine; and food and drink. In accordance with Advisory Council on the Misuse of Drugs' advice, alkyl nitrites (poppers) are deemed not to have a direct psychoactive effect and so do not fall within the scope of the act (Advisory Council on the Misuse of Drugs, 2016a). Volatile psychoactive substances (for example aerosols and solvents) are covered if it is suspected that they are going to be used for their psychoactive effects.

The supply, production and trafficking of such psychoactive substances are all prohibited under this legislation. While simple possession in the community under this legislation is not an offence, possession of a psychoactive substance within a custodial institution is prohibited, and applies to prison staff and visitors as well as inmates. The maximum penalties for each offence are the same for every substance covered by the legislation; penalties under the act are covered in section 8.3.1.

The *Psychoactive Substances Act 2016* also provides for the use of several civil sanctions which allow enforcement agencies to adopt a proportionate response to the sale of psychoactive substances. The act has been effective in stopping the open sale of NPS through physical

93 See: https://www.gov.uk/government/policies/reducing-drugs-misuse-and-dependence/supporting-pages/classifying-and-controlling-drugs

94 Any substance which, by stimulating or depressing the person's central nervous system, affects the person's mental functioning or emotional state upon consumption

premises.[95] Furthermore, the act gives law enforcement agencies powers to close down UK-based websites trading in these substances. It is worth noting that an individual purchasing a psychoactive substance from a non-UK-based website may commit the offence of importation, and could be subject to the penalties associated with this offence.

8.2.4 Temporary class drug orders

Prior to the implementation of the *Psychoactive Substances Act 2016*, the principle legislative response designed to tackle NPS was the creation of TCDOs, as part of the *Police Reform and Social Responsibility Act 2011* (Her Majesty's Government, 2011). This act added provisions for 12-month TCDOs to be made on specified compounds, putting these substances in a 'temporary class' under the *Misuse of Drugs Act 1971*. Therefore all the offences under the *Misuse of Drugs Act 1971*, with the exception of the possession offence, apply to these substances for the duration of the TCDO (see section 8.3.1). While the *Psychoactive Substances Act 2016* grants similar powers to law enforcement to act against those trafficking or supplying any psychoactive substance, TCDOs enable police to seize and destroy substances found in personal possession. As such, the option of using TCDOs remains a potentially useful one available to the government.

8.3 Drug law offences

8.3.1 Types of offences and range of penalties

Penalties under the Misuse of Drugs Act 1971 and the Psychoactive Substances Act 2016

There are a number of activities related to controlled drugs that are considered offences under the *Misuse of Drugs Act 1971* (Her Majesty's Government, 1971). These are: possession; supply; possession with intent to supply; production; importation and exportation; and offences related to permitting the production, supply or use of a controlled drug on premises. The severity of the penalty applied is dependent on the class of the drug involved and the individual circumstances of the case. For each type of offence, the court has to consider the size of the operation/quantity of drugs involved, the individual's role in the crime and any aggravating or mitigating factors in order to impose an appropriate penalty in accordance with the definitive guidelines (Sentencing Council, 2009, 2012).

Table 8.1 summarises the maximum penalties according to the offence, the classification of the drug involved, and the mode of prosecution (offences tried on indictment are those tried in a Crown Court; summary offences are those tried in a magistrates' court).

95 See: https://www.gov.uk/government/news/psychoactive-substances-ban-6-months-on-almost-500-arrests-and-first-convictions

Table 8.1: Maximum penalties for drug possession, supply, intent to supply and production in the United Kingdom under the Misuse of Drugs Act 1971 and the Psychoactive Substances Act 2016 (PSA), by drug classification

Class	Examples of drugs covered	Mode of prosecution	Possession	Supply, intent to supply, and production
A	Crack cocaine, powder cocaine, heroin, LSD, MDMA, methadone, methamphetamine, psilocybin-containing mushrooms, U-47,700	Indictment	Up to seven years in prison, an unlimited fine, or both	Up to life in prison, an unlimited fine, or both
		Summary	Up to six months in prison, a £5,000 fine, or both	Up to six months in prison, a £5,000 fine, or both
B	Amphetamines, barbiturates, cannabis, codeine, ketamine, methylphenidate (and related compounds including ethylphenidate), synthetic cannabinoids, synthetic cathinones, methiopropamine	Indictment	Up to five years in prison, an unlimited fine, or both	Up to 14 years in prison, an unlimited fine, or both
		Summary	Up to three months in prison, a £2,500 fine, or both	Up to six months in prison, a £5,000 fine, or both
C	Anabolic steroids, benzodiazepines (including 'designer' benzodiazepines such as etizolam), GHB, GBL, khat, piperazines (such as benzylpiperazine)	Indictment	Up to two years in prison, an unlimited fine, or both*	Up to 14 years in prison, an unlimited fine, or both
		Summary	Up to three months in prison, a £1,000 fine, or both*	Up to three months in prison, a £2,500 fine, or both
TCDO	No substances currently controlled by TCDO	Indictment	None, but police can take away a suspected temporary class drug	Up to 14 years in prison, an unlimited fine, or both
		Summary	None, but police can take away a suspected temporary class drug	Up to six months in prison, a £5,000 fine, or both
PSA	All psychoactive substances not covered by the *Misuse of Drugs Act 1971* or otherwise exempt	Indictment	None†	Up to seven years in prison, an unlimited fine, or both
		Summary	None†	Up to 12 months in prison, an unlimited fine, or both

*With the exception of anabolic steroids, where possession for personal use is not an offence

†Possession within a custodial institution is an offence

Source: https://www.gov.uk/penalties-drug-possession-dealing

Additional penalties under the Psychoactive Substances Act 2016

For drugs that fall under the scope of the *Psychoactive Substances Act 2016*, there is an additional offence of possession within a custodial institution, which incurs a fine and/or a maximum custodial sentence of 12 months for a summary conviction, or two years on indictment. Furthermore, there are four civil sanctions within the act (premises notice, prohibition notice, premises order and prohibition order) which are intended to target shops or websites selling NPS. Failure to comply with a premises or prohibition order also constitutes an offence. This

offence carries the same maximum penalties as possession within a custodial institution, as outlined above (Her Majesty's Government, 2016c).

Cannabis and khat warnings

First and second simple possession offences for cannabis and khat (for personal use) are dealt with using out-of-court disposals in England and Wales. In the case of first offences with no aggravating factors, this takes the form of a spoken 'warning'. Second offences generally incur a penalty notice for disorder (PND) of £80 under the *Criminal Justice and Police Act 2001* and the schedule to *The Penalties for Disorderly Behaviour (Amount of Penalty) Order 2002* (Her Majesty's Government, 2001a, 2009).

Recorded Police Warning scheme

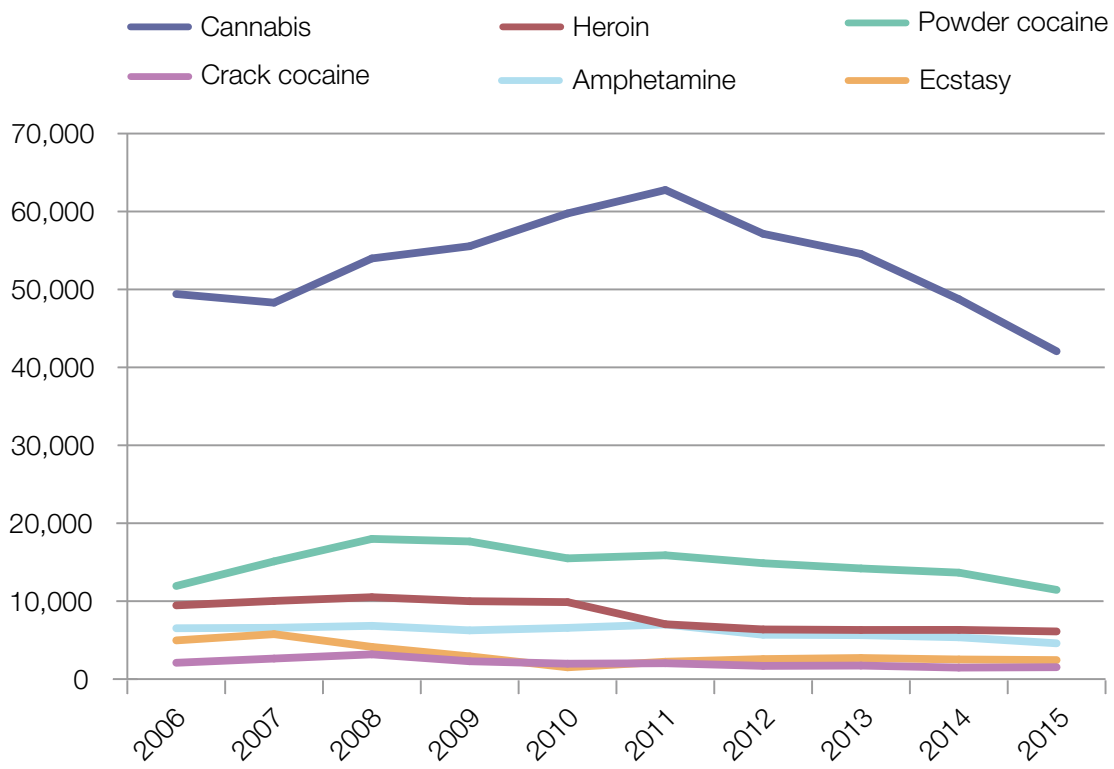
In January 2016 Police Scotland, in conjunction with the Crown Office and Procurator Fiscal Service, implemented the recorded police warning (RPW) scheme in Scotland. This allows police officers dealing with low-level offenders aged over 16 (for example, those caught in possession of a small amount of cannabis) to administer an RPW as an on-the-spot disposal at their discretion. An RPW can be used for offences which, if they were instead formally reported to the Procurator Fiscal, would most likely result in no action being taken due to the minor nature of the offence, or a non-court disposal being administered by the Procurator Fiscal. However, if the RPW is refused or appealed, a formal report may be sent to the Procurator Fiscal. RPWs will be recorded on the Criminal History System for two years, but are not a finding of guilt.

8.3.2 Drug law offences statistics

Data on drug law offences is available from various points in the criminal justice system. The most detailed data available is for cautions and convictions. This dataset records the number of offences where an individual is found guilty at court or cautioned for a drug offence. It should be noted that changes in police activities and priorities will impact on the recording of drug offences and, as such, trends may not be entirely reflective of underlying levels of drug offending.

The number of cannabis possession offences in 2015 was the lowest that it has been over the past decade, having fallen by 10% from 2013 to 2014, and a further 15% to 2015 (see Figure 8.1). This drop is seen also seen in the number of supply offences (see Figure 8.2). Cannabis possession and supply offences peaked in 2011 and 2012, respectively. As well as being the drug most commonly involved in convictions and cautions for drug law offences, it should be noted that a large number of cannabis possession offences are dealt with by cannabis warnings (see Out-of-court disposals and sentencing of drug offenders section below) and are therefore not included in these figures.

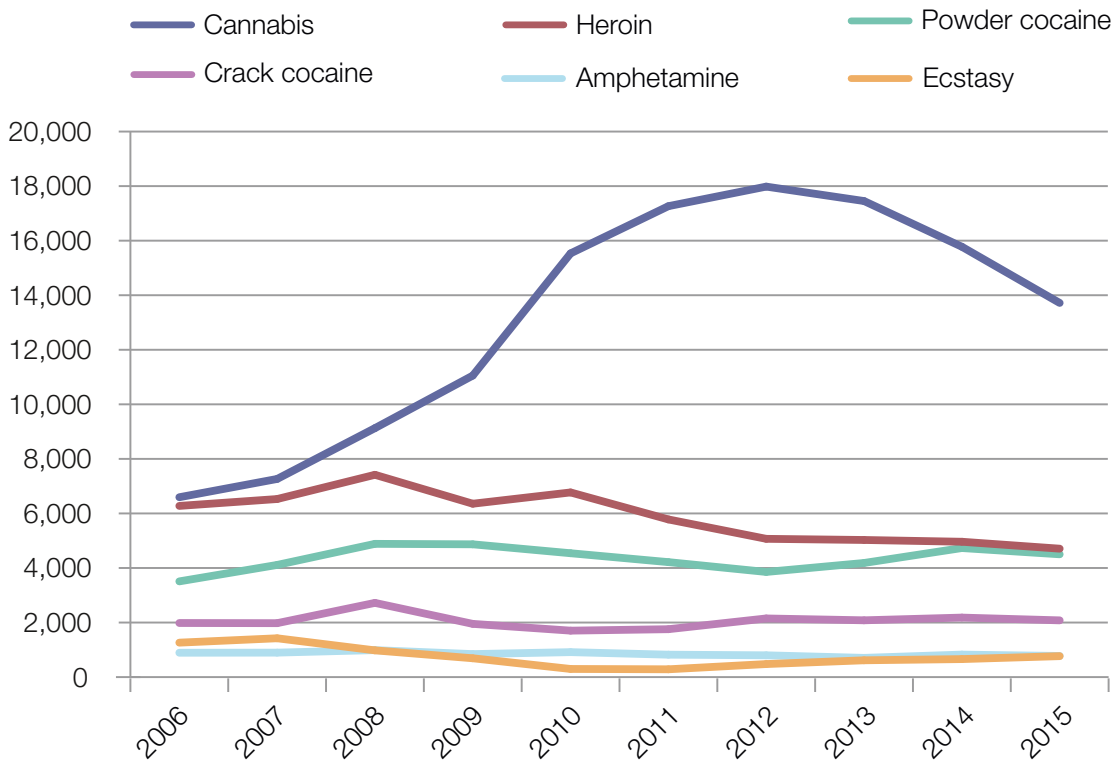
Figure 8.1: Number of possession drug offences in the United Kingdom by drug, 2006 to 2015



Source: Accompanying table 6.1

Having fallen sharply from 2010 to 2012 (a total decrease of 31%), convictions relating to heroin have plateaued. The decrease of convictions seen between 2010 and 2012 may reflect the reduced availability of heroin during this period – a pattern seen in other indicators, including seizures (see section 9.4.1). Cocaine powder possession convictions have steadily decreased since 2008, with a 16% reduction in 2015 from 2014. There was a similar decrease in the number of amphetamine possession offences (15%) between 2014 and 2015. The number of convictions for other drugs has remained fairly stable, apart from ecstasy offences, which reached a nadir in 2010 and increased again in the following years. This most likely reflects the decrease in availability of MDMA seen worldwide in the late 2000s and early 2010s, with the increase in offences occurring as MDMA re-entered the market. This matches the pattern seen in the quantity of MDMA seized since 2010/11 (see section 9.4.1).

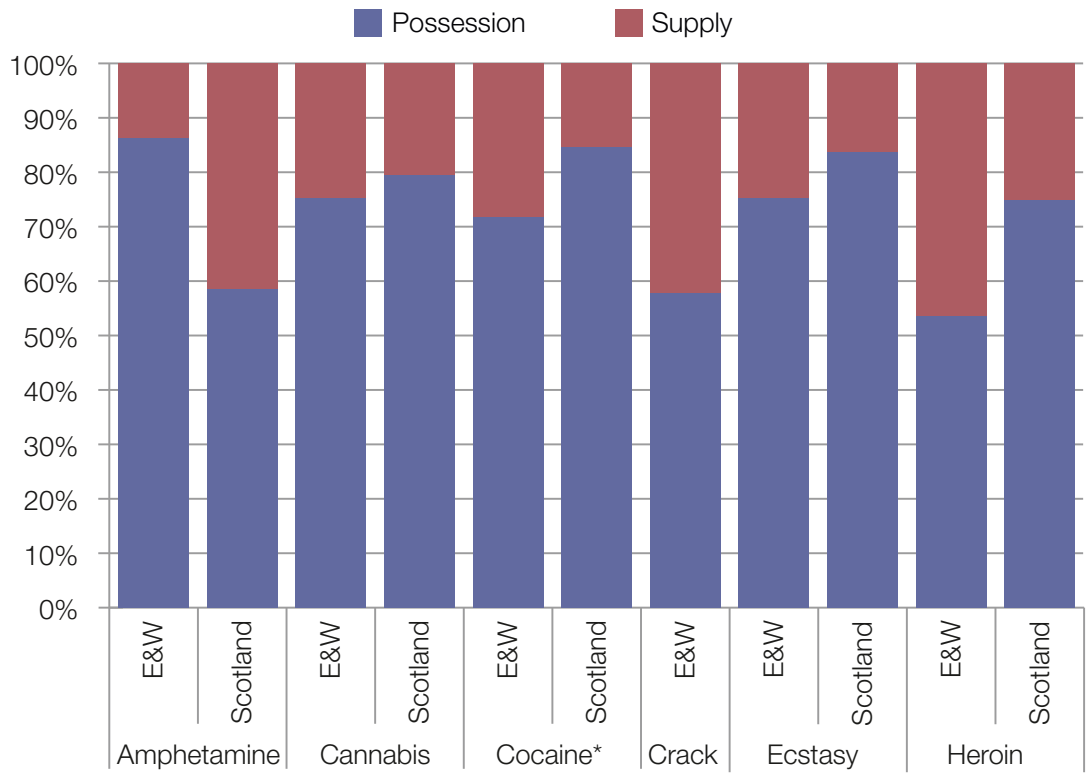
Figure 8.2: Number of supply drug offences in the United Kingdom by drug type, 2006 to 2015



Source: Accompanying table 6.1

Generally, possession offences were the most common type of offences issued across all countries; however, the proportion of possession to supply offences varies across the UK. Almost all convicted offences in Northern Ireland were possession related, whereas one-fifth and one-quarter of all convictions were supply-related in Scotland and England & Wales, respectively (see accompanying tables 6.2 and 6.3). Differences can also be found across drug types between the countries of the UK. In comparison to England & Wales, Scotland has proportionately more supply offences for amphetamines (14% and 41%, respectively) but the opposite is true in regards to heroin supply offences (46% and 25%, respectively) (see Figure 8.3)

Figure 8.3: Proportion of possession and supply offences, by drug, recorded in England & Wales and Scotland, 2015



*Scottish figures do not separate powder cocaine and crack cocaine drug law offences

Source: Accompanying tables 6.2 and 6.3

Out-of-court disposals and sentencing of drug offenders

In 2016, there were 102,948 proven drug law offenders[96] in England and Wales (Ministry of Justice, 2017a), representing a 12% decrease from the previous year, which itself was a decrease of 19% from 2014. The majority of drug offences were dealt with outside of a court setting (57%). Of these, over half (57%) were in the form of a cannabis or khat warning, one-third (32%) cautions, and 11% were PNDs (see Table 8.2).

96 Defendants who have been proven to have committed an offence (includes convictions, cautions, cannabis warnings and PNDs)

Table 8.2: Out-of-court disposals issued for drug offences in England and Wales, 2009 to 2016

	2009	2010	2011	2012	2013	2014	2015	2016
Cannabis/khat warning*	91,218	82,377	80,043	70,118	65,801	50,431	38,173	34,252
PND for cannabis possession	11,491	13,916	16,277	15,616	13,814	11,417	8,393	6,601
PND for khat possession	–	–	–	–	–	10	15	6
Cautions for drug offences†	43,808	40,721	43,056	39,783	36,386	30,825	23,330	19,457

*Data is for cannabis warnings from 2009 to 2014, and cannabis/khat warnings in 2015 to 2016

†Cautions can be issued for the following drug offences: possession of a controlled drug; unlawful important; unlawful exportation; production, supply and possession with intent to supply a controlled drug; other drug trafficking offences; permitting premises to be used for unlawful purposes; inciting others to supply a controlled drug; and other offences

Source: (Ministry of Justice, 2014, 2015, 2016a, 2017a)

Of the 41,831 individuals sentenced at court in 2016 for drug offences in England and Wales, 21% were given immediate custody (Ministry of Justice, 2016a, 2017a) (see Table 8.3). The most common sentence was a fine, meted out in 36% of cases. The vast majority (80%) of those convicted of import/export offences, and just over half (51%) of those convicted of trafficking offences (including supply offences) received immediate custody. Over half (54%) of individuals convicted of a possession offence were subjected to a fine as punishment.

Table 8.3: Number and percentage of offenders receiving each disposal at court for drug offences recorded in England and Wales, by offence type, 2016

	Immediate custody		Suspended sentence		Community sentence		Fine		Other		Total sentenced	
	n	%	*n*	%	*n*	%	*n*	%	*n*	%	*n*	%
Import/export	318	80.1	64	16.1	8	2.0	2	0.5	5	1.3	397	100
Trafficking*	7,459	50.9	3,939	26.9	2,023	13.8	707	4.8	522	3.6	14,650	100
Possession	1,009	3.8	820	3.1	3,416	13.0	14,227	54.3	6,745	25.7	26,217	100
Other	74	13.1	136	24.0	155	27.3	121	21.3	81	14.3	567	100
Total	**8,860**	**21.2**	**4,959**	**11.9**	**5,602**	**13.4**	**15,057**	**36.0**	**7,353**	**17.6**	**41,831**	**100**

*Includes production, supply and possession with intent to supply

Source: (Ministry of Justice, 2017a)

In Scotland it was reported that 5,827 RPWs for cannabis possession had been issued in 2016/17;[97] this represented approximately one-fifth of the disposals for cannabis, with the majority resulting in a report to the Procurator Fiscal (personal communication – Police Scotland).

8.3.3 Other drug-related crime

Police records on general criminal offences do not contain information on offenders' drug use, and neither do records of specific drug law offences. It is therefore not possible to provide an accurate estimate of the number of offences that are drug-related. Despite the complexity of the

97 See: http://www.scotsman.com/news/politics/thousands-of-scots-caught-with-cannabis-let-off-with-a-warning-1-4498711

drugs-crime relationship, there is research evidence of the link between drug use, particularly use of heroin and crack cocaine, and acquisitive crime (Home Office, 2007). More recent surveys have shown that around half of those in custody in England and Wales reported drug use in the two months prior to imprisonment (Her Majesty's Inspectorate of Prisons, 2015), with 25% of male prisoners and 41% of female prisoners stating that they had drug misuse needs upon arrival at prison (Her Majesty's Inspectorate of Prisons, 2016) (see section 5.3.1).

8.4 New developments

8.4.1 Recent changes to drug misuse legislation

For an overview of changes made to drug misuse legislation in 2017, see Table 8.4.

Table 8.4: Changes made to drug misuse legislation in 2017

Drugs included	Change
"Designer benzodiazepines", including etizolam, diclazepam and flubromazepam	Controlled as Class C substances under the *Misuse of Drugs Act 1971* and placed in Schedule 1 of *The Misuse of Drugs Regulations 2001* (Her Majesty's Government, 2017e)
U-47,700	Controlled as a Class A substance under the *Misuse of Drugs Act 1971* and placed in Schedule 1 of *The Misuse of Drugs Regulations 2001* (Her Majesty's Government, 2017e)
Methylphenidate-related NPS (including ethylphenidate)	Moved from being controlled by a TCDO to being controlled as Class B substances under the *Misuse of Drugs Act 1971* and placed in Schedule 1 of *The Misuse of Drugs Regulations 2001* (Her Majesty's Government, 2017e)
Methiopropamine	Moved from being controlled by a TCDO to being controlled as a Class B substance under the *Misuse of Drugs Act 1971*, and placed in Schedule 1 of *The Misuse of Drugs Regulations 2001* (Her Majesty's Government, 2017d)

8.4.2 The Modern Slavery Act 2015 and county lines

The *Modern Slavery Act 2015* (Her Majesty's Government, 2015a) was enacted in England and Wales in 2015 with the intention to clarify existing offences related to slavery and human trafficking, provide new civil preventative orders, and increase the maximum penalty for such offences. The act has been noted by representatives of the National Crime Agency to be a potentially useful tool in addressing county lines, a drug distribution system that often involves exploiting vulnerable people such as children and current drug users (see section 9.2.3) (National Crime Agency, 2016). In December, 2017, this potential was realised in the first county lines-related human trafficking conviction under the powers of the act.[98]

98 See: https://www.theguardian.com/uk-news/2017/dec/06/mahad-yusuf-fesal-mahamud-guilty-human-trafficking-drug-bust-uk-legal-first-london-swansea

9 Drug markets

9.1 Introduction

Most of the identified drug supply chains to the UK follow well-established trafficking routes. Heroin originates from Afghanistan and is transited through Pakistan, Iran or in some cases the Ukraine. Cocaine is produced in Colombia, Peru and Bolivia, with the Netherlands and Belgium being the main transit hubs within Europe for cocaine en route to the UK. The Netherlands and Belgium are also the most significant sources of traditional synthetic stimulant drugs such as MDMA and amphetamine, while the majority of new psychoactive substances (NPS) bought online originate in China. South and west Africa and the Caribbean are the main sources of herbal cannabis, while resin mainly comes from Morocco and Afghanistan. Branded strains of high potency flowering head cannabis are primarily imported from the Netherlands. Cannabis is also cultivated in significant quantities across the UK, with production being controlled for the most part by British organised crime groups (OCGs). Crack cocaine is converted domestically from imported cocaine powder. Amphetamine is also produced in the UK, with laboratories believed to be most commonly located in the north-west of England.

The average purities of powder and crack cocaine at user-level were 54% and 71% in 2016, respectively, continuing an upward trend from a nadir in 2008, and the highest recorded purities since the start of the time series in 2003. Having risen for four successive years up to 2015, the average heroin purity at user-level appears to have stabilised, and was marginally lower in 2016 (at 43%) than the previous year (44%).

Long-term drug seizure trends show a marked decrease in the number of cannabis resin seizures, as herbal cannabis has come to dominate the market (see section 1.3.2). There has been a drop in the overall number of seizures made in recent years, mainly due to a decrease in cannabis seizures.

Over the past two years, there has been widespread national activity to support the implementation of the *Psychoactive Substances Act 2016*. Since this act came into force, over 300 retailers across the UK have either closed down or stopped selling psychoactive substances, police have arrested suppliers, and action by the National Crime Agency (NCA) has resulted in the removal of psychoactive substances being sold by UK-based websites (see section 8.2.3).

Although relatively rare in the UK, there was a spate of deaths related to fentanyls (particularly carfentanyl) in the first half of 2017, concentrated in the north of England. This particular incident abated, following the arrests of suppliers and the removal of a large quantity of fentanyls from the supply chain, but concern remains that there is demand for these drugs if supply were to be re-established (see section 9.5.1).

9.2 Supply to and within the United Kingdom

The commentary provided below is based on correspondence with the NCA.

The UK drug market is exploited by a diverse demographic of drug dealers and distributors of a wide range of nationalities at all levels of the market. Nationals from more than 30 countries are believed to influence the drugs threat at organised crime-level within the UK. There is a strong link between the criminal use of firearms and drug trafficking. In 2016, over 85% of mapped firearms OCGs were also engaged in drug trafficking.

9.2.1 International trafficking routes

Cannabis

The Netherlands is the primary source for high potency (flowering head) cannabis imported into the UK. Points of entry are most commonly north-east, east and south-east coast ports, either direct from the Netherlands or via France. The most common sources for lower potency herbal cannabis are South Africa, west Africa and the Caribbean. Importation to the UK is frequently direct via air couriers, maritime freight vessels and containers.

Morocco and Afghanistan are the major sources for UK-bound cannabis resin. Moroccan resin generally routes overland via Spain and France, although much enters the UK directly in maritime freight. The Netherlands is a hub for cannabis resin destined for the UK, with south-east ports being the primary UK access points. Afghan resin tends to follow traditional heroin routes into the UK (see Heroin section below).

Cocaine

Colombia, Peru and Bolivia remain the key sources of cocaine for European and UK markets, with shipments moving either directly from these countries, or via the key transit regions of South America, the Caribbean and west Africa. Cocaine is now also trafficked via Morocco, using established cannabis trafficking routes.

Cocaine is transported to the UK from South America by both air and sea, using a wide range of methods and routes. These include air couriers on commercial flights, air freight, fast parcels and postal services, and private aircraft. By sea, cocaine is smuggled in large consignments using containerised traffic, merchant vessels, and private yachts. Higher quantities of cocaine are now being shipped directly to the UK instead of into European hubs; however, shipment of cocaine across the channel in commercial traffic from the Netherlands and Belgium remains the main method of importation into the UK, with ports on the north-east, east, south-east and south coasts of England being the most common entry points.

Yachts are frequently used to transport cocaine across the Atlantic, often sailing from Caribbean islands to the Iberian Peninsula. Cape Verde is an important trans-Atlantic staging post, as are other west African countries along the Atlantic coastline. From there, cocaine is distributed onwards to destinations across Europe, arriving in the UK by vehicle (mainly commercial vehicles), but with general aviation (smaller aircraft/micro-craft) increasingly being used.

Air couriers traffic cocaine direct from South America and the Caribbean in addition to transiting via west Africa, European hubs and (recently) the Middle East. South Africa is also a key transit location, with traffickers utilising the cover of air- and sea-facilitated trade routes and legitimate consignments.

Heroin

Heroin destined for the UK principally originates in Afghanistan, mostly transiting through either Pakistan or Iran (depending upon the onward direction of travel). Some UK-bound heroin may also arrive into the EU via Ukraine, having travelled north from Afghanistan through central Asia. Heroin that comes to the UK via Pakistan is either sent directly by parcel, air courier or maritime container; or is trafficked by sea onto eastern or southern Africa for onward movement.

Heroin destined for the UK by land typically enters Turkey via Iran or Iraq, known as the ‘Balkan Route’. Heroin is most commonly conveyed by land in goods vehicles along the Balkan Route. The majority of these vehicles travel to the Netherlands, where the heroin is stored in warehouses before onward transportation to the UK in smaller quantities. The UK is most

commonly accessed using 'roll on-roll off' haulage and commercial and private vehicles via south-east and north-east coast ports, with heroin concealed within vehicle structures, cavities and consignment loads.

Amphetamine and MDMA/ecstasy

Synthetic stimulant drugs are primarily sourced in the Netherlands and Belgium, with typical points of entry at ports in north-east, east and south-east England, either direct from the Netherlands or via France.

New psychoactive substances

China remains the principal source of NPS, although intelligence gaps exist on evolving supply methods and routes, including via European hubs.

9.2.2 Domestic production

Cannabis

There is widespread domestic production of high potency cannabis across the UK, with demand being mainly for high potency flowering head product. The demand for branded varieties remains high, with these commanding a premium price; however, the majority of cannabis produced in the UK is non-branded. Most production sites in the UK are domestic dwellings, which are often converted with rooms fitted for different stages of production: seedling/cutting propagation; developing plants; those in final/harvest stages; and post-harvest drying. These operations use equipment such as grow lights to produce an environment where cannabis can be harvested in 10 to 12 week cycles. Initial start-up costs can run into thousands of pounds (GBP), but cyclical commercial scale production remains highly profitable. Production is predominantly controlled by British OCGs; involvement of south-east Asian OCGs utilising the labour of unauthorised immigrants and victims of modern day slavery is significant, but in decline.

Amphetamine

The detected occurrences of the importation of amphetamine base from mainland Europe to the UK has decreased, whereas the importation of precursors has become more common, with identified seizures of benzyl methyl ketone and -phenylacetoacetonitrile in the last year. Although this indicates UK production, no laboratories were discovered during 2016. It is believed that production is particularly common in north-west England.

9.2.3 Supply within the United Kingdom

Typical deal sizes and modes of transaction

Most 'traditional' drugs used within the UK, such as heroin, cocaine powder and amphetamines, are traded at the wholesale-level in single, multiple, tens and even hundred plus kilogram batches. Wholesale batches of crack cocaine and NPS tend to be relatively small (often under one kg per transaction).

Though rare in the UK, fentanyl and its analogues are sold to suppliers through the dark net and are trafficked through the postal system. There has also been some adulteration of the heroin supply, particularly in north-east England, which is believed to have contributed to a spike in drug deaths in the first half of 2017. NPS are often ordered over the internet by the end user in quantities of less than one kg, and are transported within the UK via traditional postal and parcel delivery services.

Unit sizes commonly reflect traditional and long established unit weights of kg, part (1/4 or 1/2) kg and ounce. Towards the user-level, trades are commonly in the region of fractions of an ounce (1/2, 1/4, 1/8 and 1/16), then grams and part grams (0.1 and 0.2). In many cases (for powder drugs), division and adulteration are combined to extend profit margin opportunities (see section 9.3.4 and section 9.3.5).

The 'county lines' phenomenon

In recent years, a phenomenon referred to as 'county lines' has emerged, whereby urban gangs distribute heroin and crack cocaine into rural and coastal towns, and cities from central hubs. The gangs acquire drugs from OCGs, send 'runners' out to establish markets in wider locations and then exploit young and/or vulnerable people to facilitate onward supply, movement of money, and to secure safe houses (known as 'cuckooing'). This activity is facilitated via a 'line': a trusted mobile phone number accessed by customers having been introduced by a runner. The line facilitates a 24-hour demand and supply market, with the anonymised mobile phone commonly being isolated in an urban location, with runners able to respond to requests upon demand. London is the main urban export hub but there are gangs based in other cities involved in this practice as well.

The NCA published a national overview on the threat of county lines drug supply, violence and exploitation in November 2017 (National Crime Agency, 2017). Drawing on responses from 43 territorial police forces across England and Wales, evidence of county lines activity was reported in 88% of force territories, with 81% and 30% of forces having evidence of importing and exporting by county lines, respectively (see section 9.5.2).

Money laundering

Drug transactions are almost entirely cash-based, which generates the requirement to account, move, exchange and repatriate money on an industrial scale. These functions tend to be performed by specialist money launderers, who accept the risk for transmission of the cash under their control in return for a percentage fee. There are many methods employed, but commonly cash is converted into large denomination euro notes and smuggled to the near continent – often the Netherlands – to pay for consignments.

Another method used to launder street cash is via largely Asian and Middle Eastern networks using the 'informal value transfer' system (criminal exploitation of hawala banking). Much of this is undertaken by money service bureaux which receive cash, disguise its origins, and transmit to third countries. Payment is made to suppliers as part of a complex series of transfers. There are regular interdictions of street cash, typically in quantities of £100,000 to £500,000.

9.3 Price and purity

9.3.1 Market influences

The value of the GBP against the US dollar and euro remains an important factor in drug market trends, as both cocaine and heroin are traded in these currencies en route to the UK, as well as within distribution hubs accessed by OCGs supplying the UK. When the value of the pound drops, no market adjustment is made by suppliers to UK-based customers, hence less spending potential following exchange and greater wholesale outlay leads to reduced profit margins. This has previously generated UK domestic wholesale price increases.

Despite significant cocaine seizures between 2014 and 2016, the wholesale cocaine price (by kg) declined by about 15% over the same period. Part of the decline can be explained as a

recovery from overly inflated prices that had to settle down as they were generating adulteration down to unacceptable purity levels on the retail market. It is also accepted, however, that the high volumes of cocaine being smuggled towards and into the UK are compensating for the losses and allowing a competitive market to prevail. This is reflected in lower wholesale prices, less need to bulk and higher purity user deals at the same retail prices as before this period.

9.3.2 Wholesale drug market prices

The kg remains the most common wholesale trading weight for all solid and powder drugs, with the exception of crack cocaine, which is packaged following domestic conversion. As such, an ounce (28 grams) has become the most frequently encountered trading unit for this substance, with each ounce capable of making approximately 280 x 0.1 gram 'rocks'. Tablet and paper tab drugs, such as ecstasy and LSD, are most commonly traded in 1,000, 5,000 and 10,000 unit batches at wholesale. Common wholesale prices are shown in Table 9.1.

Table 9.1: Common wholesale prices of selected drugs in the United Kingdom, 2016

	Unit	Mode price	Price range	
			Lowest	Highest
Amphetamine	kg	£1,500	£1,000	£3,000
Cannabis (herbal)	kg	£1,000	£600	£1,200
Cannabis (flowering head/bud)	kg	£4,500	£3,000	£8,000
Cannabis (resin)	kg	£1,000	£700	£1,200
Cocaine	kg	£33,000	£28,000	£38,000
Heroin	kg	£23,000	£19,000	£25,000
MDMA (powder/crystal)	kg	£5,000	£3,000	£8,000
MDMA (tablets)	1,000 tablets	£1,500	£1,000	£1,600

Source: Accompanying table 7.1

9.3.3 Street-level prices

Street-level (or retail) deals tend to be in one gram units for amphetamine, MDMA powder/crystal, mephedrone, ketamine and high potency cannabis, with other cannabis types typically being sold for 1/8 ounce (3.5 grams). Heroin and crack cocaine are commonly sold as 'bags' and 'rocks' respectively, in 0.1 gram and 0.2 gram deals. Traditionally, cocaine powder has been sold in one gram units; however, with the recent trend for high quality unadulterated cocaine, sub-half gram units of 0.1 and 0.2 grams have emerged within the market. Typical street-level drug prices are shown in Table 9.2.

Table 9.2: Common street-level prices of certain illicit drugs in the United Kingdom, 2007 to 2016

	Price per gram except where otherwise stated									
	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Amphetamine	£9.00	£10.00	£10.00	£10.00	£10.00	£10.00	£10.00	£10.00	£10.00	£10.00
Cannabis (herbal)*	£3.95	£2.85	£2.85	£2.82	£5.00	£5.00	£3.00	£2.86	£2.86	£2.86
Cannabis (flowering head/bud)†	£6.21	£5.63	£7.15	£7.15	£10.00	£10.00	£8.50	£15.20	£10.00	£10.00
Cannabis (resin)*	£2.82	£2.85	£2.85	£2.82	£5.00	£5.00	£3.00	£5.20	£2.86	£2.86
Cocaine powder	£46.00	£40.00	£40.00	£40.00	£40.00	£40.00	£40.00	£40.00	£40.00	£40.00
Crack cocaine	£65.00	£65.00	£60.00	£50.00	£50.00	£60.00	£60.00	£60.00	£60.00	£60.00
Ecstasy/ MDMA (per tablet)	£3.00	£3.00	£2.50	£2.50	£5.00	£3.00	£3.00	£5.00	£5.00	£10.00
Heroin	£48.00	£45.00	£45.00	£45.00	£40.00	£40.00	£50.00	£50.00	£50.00	£50.00
Ketamine	-	-	-	£25.00	£25.00	£20.00	£20.00	£20.00	£20.00	£20.00
LSD (per dose)	£3.50	£3.00	£3.00	£3.00	-	-	£3.00	£3.00	£3.00	£3.00
Mephedrone	-	-	-	£10.00	£20.00	£20.00	£15.00	-	-	£15.00

*Price per gram converted from the 3.5 gram street deal equivalent, except for between 2011 and 2013, where prices were reported on a gram basis

†Price per gram converted from the 3.5 gram street deal equivalent between 2007 and 2010; from 2011 prices are reported on a gram basis

Source: Accompanying table 7.2

9.3.4 Wholesale drug adulteration

Powdered drugs are commonly adulterated at varying levels between production and the consumer in order to fully exploit profitability within the marketplace. Cocaine is also sold in its unadulterated form as a high quality commodity for premium prices, as discussed above.

Adulteration patterns for cocaine remain unchanged from last year. Levamisole is commonly believed to be added at source, although the purpose for this remains unclear. Thereafter, benzocaine and caffeine are the most common adulterants seen in cocaine powder, with benzocaine and phenacetin seen most frequently in crack cocaine.

Caffeine and paracetamol continue to be the most common adulterants identified in heroin base seizures, with recent data showing a slight increase in the use of clotrimazole. Analyses of amphetamine powder seizures showed caffeine to be by far the most common adulterant (found in over 90% of all seizures), followed by glucose and lactose. Creatine was also identified in a small number of seizures in 2016, replicating results seen in 2014 and 2015. MDMA powder seized in the UK continues to be largely unadulterated.

9.3.5 Street-level purity

From forensic analysis, the majority of adulteration tends to take place before the drug reaches the street dealer. Their means of profit-making will therefore more often be division and reduction in deal size for the very small amounts. For example, if a street dealer buys one-eighth of an ounce of heroin (3.5 grams) and sells it in 0.08 gram, rather than 0.1 gram deals, this will provide 44 deals at £10, instead of 35 deals, giving an additional return of £90 for a small outlay.

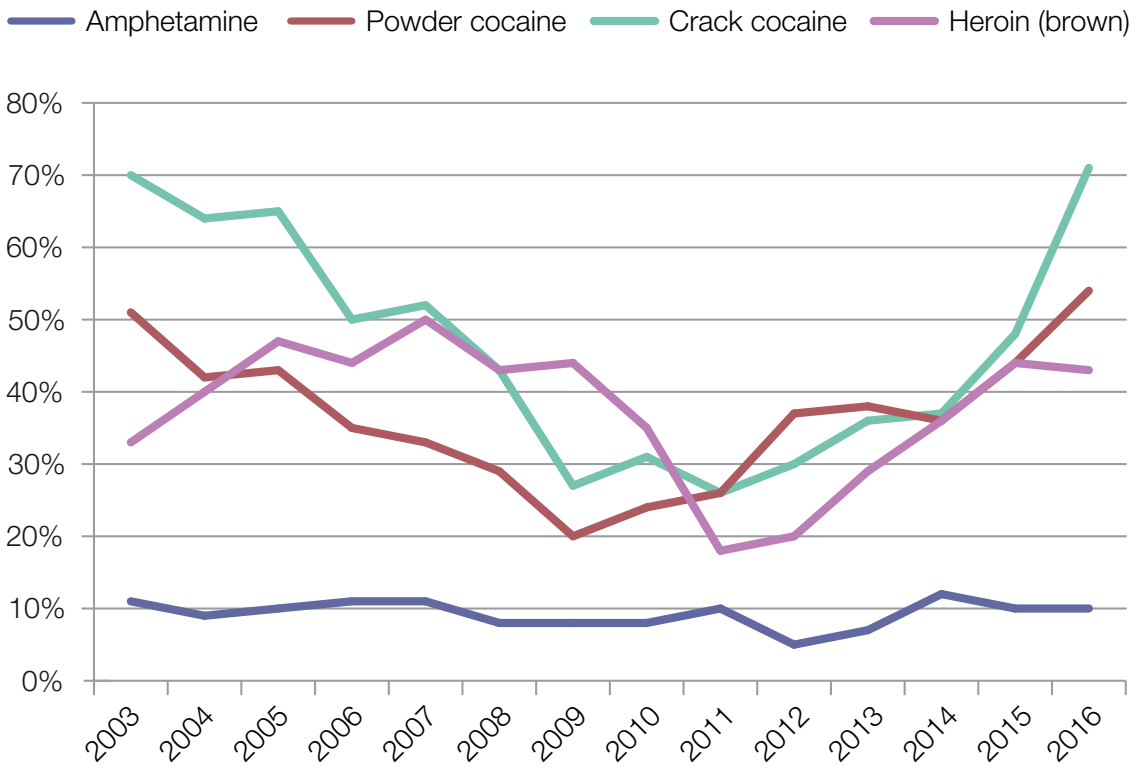
Purity of powdered drugs may be affected by the size and nature of the supply chain, of which many forms are present in the UK. Short supply chains, consisting, for example, of importer to retail supplier to user, facilitate the sale of high and bulked quality products, as control remains entirely with those importing and dealing. An example of a longer supply chain might include an importer, national distributor, regional distributor, local supplier and street dealer before reaching the consumer. In this scenario, bulking with cutting agents is likely to maximise profits at each stage. This can result in a lack of awareness of purity, as each onward transaction adds distance from the importation. In such a scenario, purity can very often only be guessed or generally assessed by use.

The average purity of powder cocaine at user-level in England and Wales has increased steadily over the last three years, from 36% in 2014 to a record high of 54% in 2016 (see Figure 9.1). Prior to this, purity had dropped steadily from 51% in 2003 to a low of 20% in 2009. Early indications suggest this trend will continue in 2017 (personal communication – NCA).

The conversion to crack cocaine occurs within the UK, therefore much of the supply-side factors affecting the purity of cocaine powder are the same for the base form. As such, the trend in purity of crack cocaine tracks that of powder (though crack purities are typically higher). Purity of user-level crack cocaine has risen from a record low of 26% in 2011 to 48% in 2015, and increased more sharply in 2016 to a record high of 71%. Early data from 2017 suggests that average purity remains exceptionally high.

Heroin purity at user-level dropped from 35% in 2010 to a low of 18% in 2011 (the year in which supply was most affected by the heroin drought). Purity of heroin subsequently rose each year, more than doubling to an all-time high of 44% in 2015. The mean of 43% recorded in 2016 (as well as provisional data for early 2017) suggests that heroin purity has now stabilised, or perhaps even slightly decreased.

Figure 9.1: Mean user-level purity of selected drugs in England and Wales, 2003 to 2016



Source: Accompanying table 7.2

Both powder cocaine and heroin could be said to have two-tier retail markets based on purity. The increases in mean purities of each drug reflect, to an extent, increased dominance of the higher quality versions of the products within the market, rather than an overall shift in the purity of a typical deal.

Average amphetamine powder purity at user-level has remained steady for several years, ranging from five per cent to 12%.

9.4 Drug seizures

9.4.1 Seizures of drugs made by police forces and Border Force

Cannabis is the most commonly seized drug in the UK, and is therefore the main influence on the trend in total number of drug seizures (see Table 9.3). The number of seizures of herbal cannabis has decreased by 26% since 2011/12. The quantity of herbal cannabis seized does not reflect this trend, as the vast majority of seizures are carried out by police forces, but Border Force is responsible for seizing the greatest quantity of herbal cannabis, which may include single high quantity seizures (see Figure 9.2) (Home Office, 2016c). There has been a substantial decrease in the number and quantity of cannabis resin seizures over the past ten years, most likely reflecting a decreased use of this type of cannabis in England and Wales (see section 1.3.2).

Table 9.3: Number of drug seizures made by police forces and Border Force in the United Kingdom, 2010/11 to 2015/16

	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Amphetamine	8,438	7,722	6,538	6,725	5,735	4,637
Benzodiazepines*	6,360	7,321	6,097	5,983	7,739	6,701
Cannabis (herbal)	147,486	155,502	148,746	147,309	128,214	115,716
Cannabis (plants)	15,526	17,618	15,846	15,744	12,443	10,390
Cannabis (resin)	29,314	24,742	17,360	14,105	12,599	11,359
Cocaine powder	20,052	19,327	15,892	19,820	19,212	19,108
Crack cocaine	5,539	5,201	4,663	4,897	4,135	4,743
Ecstasy	2,956	3,599	3,734	3,913	3,222	3,179
Heroin	14,285	11,709	10,648	10,913	10,006	10,685
Ketamine	1,823	1,574	1,425	1,650	486	536
Total	243,043	249,725	†	†	197,581	183,912

*Data for 2010/11 and 2011/12 is from England & Wales and Scotland only

†Data not available

Source: Accompanying table 7.5; (Home Office, 2016c; Scottish Government, 2017a)

While accounting for a much smaller proportion of the total, the trend in the number of cannabis plant seizures shows a similar pattern to that of herbal cannabis (see Table 9.4). There was a large increase in the number of seizures between 2006/07 (data not shown) and 2011/12, which has been followed by a downwards trend for four years. The number of cannabis plants seized decreased from 774,767 in 2010/11 to 430,628 in 2015/16, potentially reflecting changes in locally-determined policing priorities or a decrease in the domestic production of cannabis. There was a substantial drop in the number of seizures of ketamine from 1,650 in 2013/14 to 486 in 2014/15, with a similar number in 2015/16 (n=536). The quantity of ketamine seized has also been much lower in the last two years (56 kg in both 2014/15 and 2015/16) than in most years previously (for example, 357 kg was seized in 2013/14).

Table 9.4: Quantity of individual drugs seized by police forces and Border Force in the United Kingdom, 2010/11 to 2015/16

	Unit	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Amphetamine	kg	983	1,192	1,491	1,730	742	561
Benzodiazepines*	1,000 tablets	1,474.7	1,562.7	1,206.9	1,739.7	1,885.7	1,740.3
Cannabis (herbal)	kg	21,737	23,229	13,243	18,705	15,550	31,131
Cannabis (plants)	No.	774,767	672,578	555,625	484,645	392,233	430,628
Cannabis (resin)	kg	19,815	20,876	13,432	1,134	7,683	7,808
Cocaine powder	kg	2,543	3,568	3,325	3,562	3,543	4,363
Crack cocaine	kg	57	40	47	50	33	46
Ecstasy	1,000 tablets	396.0	700.8	473.1	423.0	1,149.1	825.5
Heroin	kg	832	1,968	831	785	1,221	882
Ketamine	kg	802	79	244	357	56	56

*Data for 2010/11 and 2011/12 is from England & Wales and Scotland only

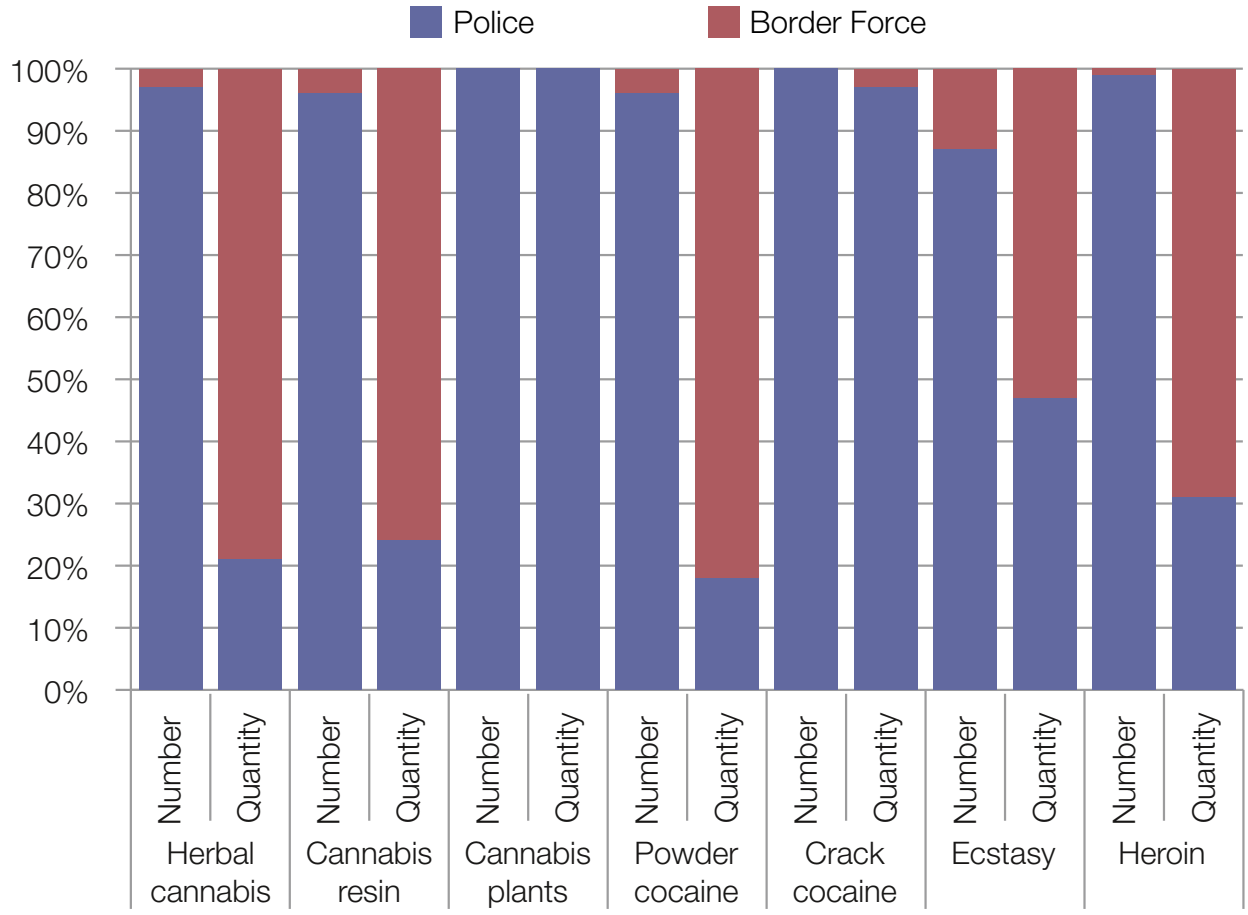
Source: Accompanying table 7.6; (Home Office, 2016c; Scottish Government, 2017a)

The number of seizures of heroin has decreased since the beginning of the decade, but has now stabilised at around 10,000 seizures per year. Similar to the cannabis data, the quantity of heroin seized over the last decade has varied greatly. This peaked at 1,968 kg in 2011/12, but more than halved the following year. Again, the quantities of heroin seized are primarily influenced by the seizures made by Border Force.

The number of cocaine powder seizures has decreased slightly since the start of the decade, but has been relatively stable, with close to 20,000 seizures in most years. The quantity of cocaine powder seized in 2015/16 was 4,317 kg, the highest amount seen in the past ten years, and a 22% increase from 3,543 kg in 2014/15. Crack cocaine seizure numbers have remained stable for the past five years, and this figure was 4,743 in 2015/16. While Border Force is responsible for seizing the greatest quantity of cocaine powder in England and Wales, virtually all crack cocaine seizures (both number and quantity seized) in England and Wales are made by the police force, reflecting the importation of cocaine powder from abroad, and the domestic production of crack cocaine within the UK (see Figure 9.2).

Seizures of ecstasy tablets (both number and quantity) declined between 2006/07 and 2010/11: in 2006/07 there were 7,758 ecstasy seizures in England and Wales alone, compared to the 2,956 made in 2010/11 (Home Office, 2016c). The number of seizures has remained relatively stable since 2010/11, but the quantity seized has increased, from 396,000 tablets to 1,149,100 tablets in 2014/15, with a fall to 825,500 tablets seen in 2015/16. However, in comparison, there were 6,611,000 tablets seized in England and Wales in 2006/07 (Home Office, 2016c). The number of seizures of benzodiazepines has not shown an increasing or decreasing trend over the past six years.

Figure 9.2: Proportion of the number and quantity of seizures made by police forces and Border Force in England and Wales, 2016/17*



*Kent police force were unable to supply reliable estimates therefore imputation methods, based on police recorded crime, have been used to estimate 2016/17 data for this force

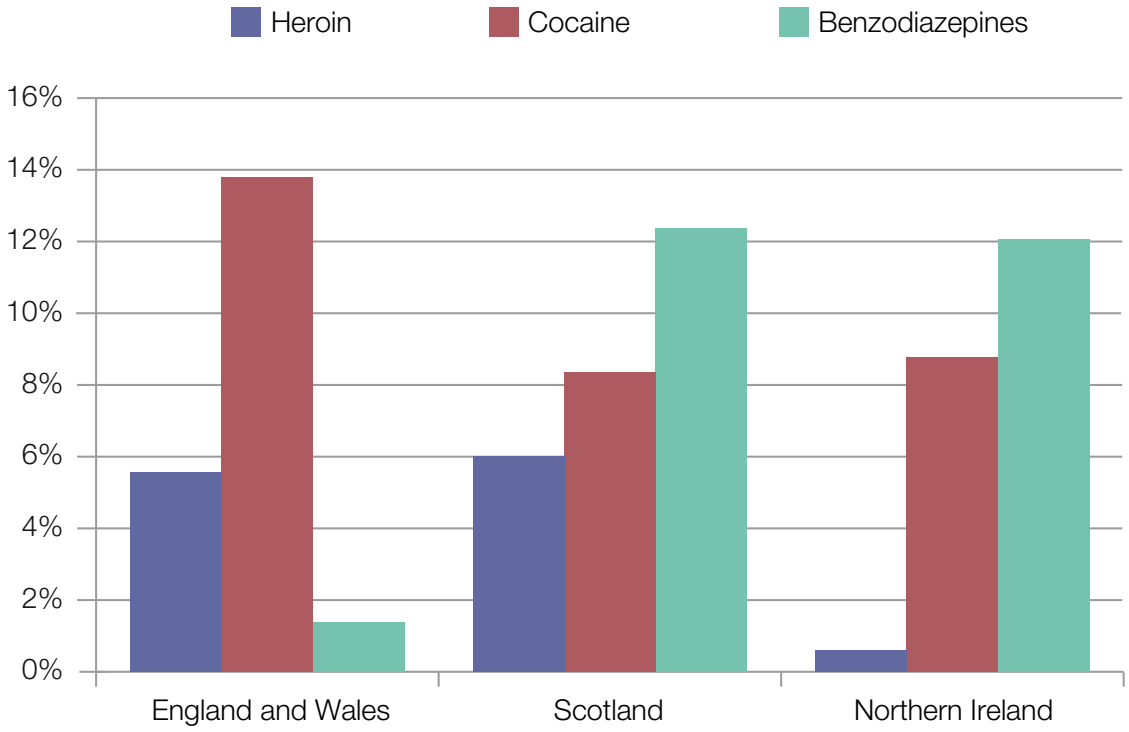
Source: (Home Office, 2017b)

9.4.2 Country comparisons of drug seizures data

Comparisons of the numbers of drug seizures made by police in the countries which make up the UK provide an insight into the very divergent drug markets that exist within them. Data for accompanying tables 7.5 and 7.6 is not supplied separately for England and Wales; due to their comparative population sizes, data for England and Wales will mainly reflect the situation in England. The latest year where data for the entire UK is available is 2015/16. Overall, drug seizures made by Scottish police in this year represented 17% of the police total for the UK, despite Scotland only accounting for eight per cent of the UK population (see accompanying table 7.5).

Figure 9.3 shows how the proportions of seizures of some selected drugs differ considerably between countries. Data for 2015/16 shows heroin seizures accounted for a far smaller proportion of total seizures in Northern Ireland (one per cent) than in the rest of the UK (six per cent). However, cocaine seizures (including both powder cocaine and crack cocaine) made up 14% of the seizures from England and Wales, compared to eight per cent in Scotland and Northern Ireland.

Figure 9.3: Selected drugs seized as a proportion of all police seizures in England & Wales, Scotland and Northern Ireland, 2015/16



Source: Accompanying table 7.5

Seizures data suggests that herbal cannabis dominates the market in England and Wales but less so in Scotland, where resin is relatively commonly seized (see section 1.3.2). Northern Irish police made 53 seizures of tramadol tablets in 2015/16, which was almost half the number seized in England and Wales combined (n=110) and more than the number of heroin seizures in Northern Ireland (n=33).

While benzodiazepines accounted for 12% of seizures in both Northern Ireland and Scotland, this was only one per cent in England and Wales. More than half of the benzodiazepine seizures made in the UK in 2015/16 were made by Police Scotland (4,082 of the 6,701 UK seizures). This represented more than three-quarters (77%) of the total number of benzodiazepine tablets seized in the UK (1,399,300 of the 1,740,253 tablets seized in the UK) (Scottish Government, 2017a). A sizeable proportion of seizures were also made in Northern Ireland: in 2015/16, 655 seizures were made in this country, compared to 1,964 made in England & Wales. This reflects the greater use of benzodiazepines seen in Scotland and Northern Ireland, which is also suggested by the greater proportion of treatment presentations and drug-related deaths associated with these substances.

9.5 New developments

9.5.1 Fentanyls

In early 2017, there was a spate of deaths in the north of England in early 2017 related to fentanyls in the heroin supply chain, often prepared with bulking agents to look like heroin. The fentanyls involved (predominantly carfentanyl) had been traded on the dark net prior to the arrest of several suppliers and the removal of these drugs from the supply chain. Anecdotal evidence suggests that the nature of the incident with regard to the demand side was mixed, with older heroin users generally having unwittingly taken fentanyls sold to them as heroin,

while some younger users are understood to have taken fentanyls intentionally. As well as demonstrating how dangerous these drugs are relative to heroin, the incident is concerning as it suggests there may be a ready pocket of demand for fentanyls in the area should supply be re-established.

9.5.2 National overview on the threat of county lines

The NCA published a national overview on the threat of county lines drug supply, violence and exploitation in November 2017 (National Crime Agency, 2017) (see section 9.2.3). Drawing on responses from 43 territorial police forces across England and Wales, it was found that heroin and crack cocaine remain the most commonly reported drugs being supplied by county lines methodology (reported by 79% and 70% of forces respectively).

Evidence of county lines activity was reported in 88% of force territories, with 81% and 30% of forces having evidence of importing and exporting by county lines, respectively. The Metropolitan Police force area was mentioned as the exporting hub of county lines going into 65% of other forces. Merseyside was the second highest exporter, affecting 42% of other forces. County lines originating from London predominantly impact forces in the south and east of England, but some also affect forces further north. County lines originating from Merseyside have a greater impact on forces in the north-west of England, but also impact forces in the south-east.

Seventy-seven per cent of forces documented incidents of cuckooing associated to county lines activity, and such incidents were documented by virtually every force that reported the presence of a county line end-point. Vulnerable adults targeted by gangs are predominantly addicted to Class A drugs, but the elderly, those with mental or physical health impairments, female sex workers and single mothers are also reportedly targeted. County lines groups impose high levels of violence, including the prevalent use of weapons to control and intimidate group members and victims.

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